| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

## Filing at a Glance

Company: American National Life Insurance Company of Texas

| | | |
|---|---|---|
| Product Name: MIG GAP | SERFF Tr Num: ANTX-127366701 | State: Arkansas |
| TOI: H14I Individual Health - Hospital Indemnity | SERFF Status: Closed-Approved-Closed | State Tr Num: 49548 |
| Sub-TOI: H14I.000 Health - Hospital Indemnity | Co Tr Num: | State Status: Approved-Closed |
| Filing Type: Form/Rate | | Reviewer(s): Rosalind Minor |
| | Author: Deborah Biediger | Disposition Date: 08/19/2011 |
| | Date Submitted: 08/15/2011 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: | Status of Filing in Domicile: Authorized |
| Project Number: | Date Approved in Domicile: 07/12/2011 |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Individual Market Type: |
| Overall Rate Impact: | Filing Status Changed: 08/19/2011 |
| | State Status Changed: 08/19/2011 |
| Deemer Date: | Created By: Deborah Biediger |
| Submitted By: Deborah Biediger | Corresponding Filing Tracking Number: |

Filing Description:

The attached Policy, form ANL-HOPS11(AR), provides fixed indemnity benefits and consists of hospital confinement, intensive care unit, outpatient surgery, outpatient diagnostic imaging, convalescent/skilled nursing facility confinement, home health care, and accidental death and dismemberment benefits. Additional optional benefits can be added to the base Policy as riders.

Critical Illness Benefit Rider, form ANL-RCI11, pays the coverage amount shown in the schedule if the covered person is diagnosed as having a covered condition. Covered conditions may include cancer, stroke, heart attack, end stage renal disease/kidney failure, or major organ transplant.

Diagnostic Imaging Benefit and Accident Rider, form ANL-RDIRACC11, pays the amount shown in the schedule for each diagnostic imaging procedure. Diagnostic imaging tests include PET, MRA, MRI, and CAT/CT. This rider also includes an accident medical expense benefit that pays 80% actual charges for treatment of an injury up to a $1,000 maximum, in excess of a $100 deductible.

Outpatient Surgical Procedure Benefit Rider, form ANL-ROPS11, pays the amount shown in the surgical procedure schedule. The amount of the benefit will be based upon the type of surgical procedure performed on an outpatient basis.

Form ANL-GAPAPP6 is the Application.

Form ANL-H11OOC is the Outline of Coverage/Pre-Enrollment Disclosure that will be given to potential applicants prior to enrollment.

Form ANL-INDDUP is the Important Notice to Persons on Medicare.

Form ANL-REPLNOT is the Replacement Notice.

ANL-CIN (AR) Rev.2011 is the Consumer Information Notice that will be included with all issued policies.

The Policy will be marketed to persons age 0-79.

The rates and actuarial memorandum are also attached.

## Company and Contact

**Filing Contact Information**


| | |
|---|---|
| Deborah Biediger, Compliance Analyst | deborah.biediger@anico.com |
| One Moody Plaza SSH MP, Ste. 200 | 281-538-4838 [Phone] |
| Galveston, TX 77550 | 409-766-2024 [FAX] |


**Filing Company Information**

| | | |
|---|---|---|
| American National Life Insurance Company of Texas | CoCode: 71773 | State of Domicile: Texas |
| One Moody Plaza, SSH MP, Ste.200 | Group Code: -99 | Company Type: Health Insurance |
| Galveston, TX 77550 | Group Name: | State ID Number: |
| (281) 538-4842 ext. [Phone] | FEIN Number: 75-1016594 | |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

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## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $450.00 |
| Retaliatory? | No |
| Fee Explanation: | $50.00 X 9 forms = $450.00<br>(our retaliatory fee is $50.00 so we are paying the required higher of the two) |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| American National Life Insurance Company of Texas | $450.00 | 08/15/2011 | 50610314 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 08/19/2011 | 08/19/2011 |

### Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---|---|---|---|---|---|---|
| **Status** | **Created By** | **Created On** | **Date Submitted** | **Responded By** | **Created On** | **Date Submitted** |
| Pending Industry Response | Rosalind Minor | 08/16/2011 | 08/16/2011 | Deborah Biediger | 08/19/2011 | 08/19/2011 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Disposition

Disposition Date: 08/19/2011
Implementation Date:
Status: Approved-Closed
Comment:

| Company Name: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where required): | Minimum % Change (where required): |
|---|---|---|---|---|---|---|---|
| American National Life Insurance Company of Texas | 0.000% | 0.000% | $0 | 0 | $0 | 0.000% | 0.000% |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | No |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Supporting Document** | red lined forms revised pursuant to Departmental objections | Approved-Closed | Yes |
| **Form *(revised)*** | HOSPITAL CONFINEMENT INSURANCE POLICY | Approved-Closed | Yes |
| **Form** | HOSPITAL CONFINEMENT INSURANCE POLICY | Replaced | Yes |
| **Form *(revised)*** | APPLICATION | Approved-Closed | Yes |
| **Form** | APPLICATION | Approved-Closed | Yes |
| **Form *(revised)*** | OUTLINE OF COVERAGE | Approved-Closed | Yes |
| **Form** | OUTLINE OF COVERAGE | Replaced | Yes |
| **Form** | CRITICAL ILLNESS BENEFIT RIDER | Approved-Closed | Yes |
| **Form** | DIAGNOSTIC IMAGING BENEFIT AND ACCIDENT RIDER | Approved-Closed | Yes |
| **Form** | OUTPATIENT SURGICAL PROCEDURE BENEFIT RIDER | Approved-Closed | Yes |
| **Form** | IMPORTANT NOTICE TO PERSONS ON MEDICARE | Approved-Closed | Yes |
| **Form** | NOTICE TO APPLICANT | Approved-Closed | Yes |
| **Form** | CONSUMER INFORMATION NOTICE | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 08/16/2011 |
| Submitted Date | 08/16/2011 |
| Respond By Date | |

Dear Deborah Biediger,

This will acknowledge receipt of the captioned filing.

Objection 1

- HOSPITAL CONFINEMENT INSURANCE POLICY, ANL-HOPS11(AR) (Form)
- OUTLINE OF COVERAGE, ANL-H11OOC (Form)

Comment: As outlined under ACA 23-79-129(a), coverage for a well newborn child must be paid for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

Objection 2

- APPLICATION, ANL-GAPAPP6 (Form)
- NOTICE TO APPLICANT, ANL-REPLNOT (Form)

Comment:

Your Notice to Applicant regarding replacement states that...."According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance....". Your application does not contain a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. Please refer to Rule and Regulation 18, Section 9 A.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 08/19/2011 |
| Submitted Date | 08/19/2011 |

Dear Rosalind Minor,

**Comments:**
Thank you for your review of this submission.

## Response 1

Comments: I have added this benefit to the Schedule of Benefits; I have added an insuring provision in the benefits section of the policy describing this benefit; and I have deleted the exclusion regarding well newborn care. The Outline of Coverage has been revised to comply with those revisions.

**Related Objection 1**

Applies To:

- HOSPITAL CONFINEMENT INSURANCE POLICY, ANL-HOPS11(AR) (Form)
- OUTLINE OF COVERAGE, ANL-H11OOC (Form)

Comment:
As outlined under ACA 23-79-129(a), coverage for a well newborn child must be paid for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: red lined forms revised pursuant to Departmental objections
Comment: red lined policy, outline of coverage and application

**Form Schedule Item Changes**

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|---|---|---|---|---|---|---|---|
| HOSPITAL CONFINEMENT | ANL-HOPS11( | | Policy/Contract/Fraternal Certificate | Initial | | | Policy.pdf |

| | | | | |
|---|---|---|---|---|
| INSURANCE POLICY | AR) | | | |
| ***Previous Version*** | | | | |
| *HOSPITAL CONFINEMENT INSURANCE POLICY* | *ANL-HOPS11(AR)* | *Policy/Contract/Fraternal Certificate* | *Initial* | Policy_with_Schedule.pdf |
| APPLICATION | ANL-GAPAPP6 (AR) | Application/Enrollment Form | Initial | GAP - AR App.pdf |
| ***Previous Version*** | | | | |
| *APPLICATION* | *ANL-GAPAPP6* | *Application/Enrollment Form* | *Initial* | GAP - Generic App.pdf |
| OUTLINE OF COVERAGE | ANL-H11OOC (AR) | Outline of Coverage | Initial | OUTLINE.pdf |
| ***Previous Version*** | | | | |
| *OUTLINE OF COVERAGE* | *ANL-H11OOC* | *Outline of Coverage* | *Initial* | GAP OUTLINE.pdf |

No Rate/Rule Schedule items changed.

## Response 2

Comments: I have revised the application to include this as question number 5 and renumbered the subsequent questions. Due to this change the application is now Arkansas state specific so I have revised the form number by adding "AR" to the policy form designation.

**Related Objection 1**

Applies To:

- APPLICATION, ANL-GAPAPP6 (Form)
- NOTICE TO APPLICANT, ANL-REPLNOT (Form)

Comment:

Your Notice to Applicant regarding replacement states that...."According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance....". Your application does not contain a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident

and health insurance presently in force. Please refer to Rule and Regulation 18, Section 9 A.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: red lined forms revised pursuant to Departmental objections
Comment: red lined policy, outline of coverage and application

**Form Schedule Item Changes**

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|---|---|---|---|---|---|---|---|
| HOSPITAL CONFINEMENT INSURANCE POLICY | ANL-HOPS11(AR) | | Policy/Contract/Fraternal Certificate | Initial | | | Policy.pdf |
| ***Previous Version*** | | | | | | | |
| *HOSPITAL CONFINEMENT INSURANCE POLICY* | *ANL-HOPS11(AR)* | | *Policy/Contract/Fraternal Certificate* | *Initial* | | | Policy_with_Schedule.pdf |
| APPLICATION | ANL-GAPAPP6(AR) | | Application/Enrollment Form | Initial | | | GAP - AR App.pdf |
| ***Previous Version*** | | | | | | | |
| *APPLICATION* | *ANL-GAPAPP6* | | *Application/Enrollment Form* | *Initial* | | | GAP - Generic App.pdf |

No Rate/Rule Schedule items changed.

Redlined versions of the revised forms are attached under the Supporting Documentation tab reflecting the revisions I have made to the forms as described above.

Sincerely,
Deborah Biediger

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Form Schedule

**Lead Form Number: ANL-HOPS11(AR)**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed 08/19/2011 | ANL-HOPS11(AR) | Policy/Contract/Fraternal Certificate | HOSPITAL CONFINEMENT INSURANCE POLICY | Initial | | | Policy.pdf |
| Approved-Closed 08/19/2011 | ANL-GAPAPP6(AR) | Application/Enrollment Form | APPLICATION | Initial | | | GAP - AR App.pdf |
| Approved-Closed 08/19/2011 | ANL-H11OOC(AR) | Outline of Coverage | OUTLINE OF COVERAGE | Initial | | | OUTLINE.pdf |
| Approved-Closed 08/19/2011 | ANL-RCI11 | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | CRITICAL ILLNESS BENEFIT RIDER | Initial | | | ANL-RCI11.pdf |
| Approved-Closed 08/19/2011 | ANL-RDIRACC11 | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | DIAGNOSTIC IMAGING BENEFIT AND ACCIDENT RIDER | Initial | | | ANL-RDIRACC11.pdf |
| Approved-Closed | ANL-ROPS11 | Policy/Contract/Fratern | OUTPATIENT SURGICAL | Initial | | | ANL-ROPS11.pdf |

| | | | | | | |
|---|---|---|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | | *State:* | *Arkansas* | | |
| *Filing Company:* | *American National Life Insurance Company of Texas* | | *State Tracking Number:* | *49548* | | |
| *Company Tracking Number:* | | | | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* | | |
| *Product Name:* | *MIG GAP* | | | | | |
| *Project Name/Number:* | */* | | | | | |
| 08/19/2011 | al Certificate: Amendment, Insert Page, Endorsement or Rider | PROCEDURE BENEFIT RIDER | | | | |
| Approved-Closed 08/19/2011 | ANL-INDDUP | Other | IMPORTANT NOTICE TO PERSONS ON MEDICARE | Initial | | Duplication Notice GAP.pdf |
| Approved-Closed 08/19/2011 | ANL-REPLNOT | Other | NOTICE TO APPLICANT | Initial | | Replacement Form GAP.pdf |
| Approved-Closed 08/19/2011 | ANL-CIN (AR) Rev.2011 | Other | CONSUMER INFORMATION NOTICE | Initial | | CONSUMER INFORMATION NOTICE.pdf |

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**

A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**

**HOSPITAL CONFINEMENT INSURANCE POLICY**

This Policy is a contract of insurance. **READ IT CAREFULLY.**

We pay benefits in accordance with all the terms and conditions of this Policy.

**IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION -** You should read Your Application and all documents attached to Your Policy. **Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

Your Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy.

We do not provide coverage until Your Application has been approved and Your Initial Premium is paid. The Initial Premium pays for Your Initial Term of coverage. Your Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Effective Date. Coverage is continued in accordance with all of the provisions of this Policy.

**30 DAY RIGHT TO EXAMINE THIS POLICY** – You may return this Policy to Us for any reason within 30 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Policy, coverage under this Policy is void from the beginning. We will refund any premium paid.

**GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER – SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL.** You have the right to continue this Policy in force subject to the termination provisions and Your continued payment of premium in accordance with all the provisions of this Policy.

**PREMIUMS ARE SUBJECT TO CHANGE -** Please refer to the section titled **PREMIUMS**.

**SECRETARY** **PRESIDENT**

**THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS. OTHER ADDITIONAL BENEFITS DESCRIBED IN THIS POLICY ARE ALSO PROVIDED.**

## POLICY SCHEDULE

| BENEFIT | BENEFIT AMOUNT |
|---|---|
| **MEDICAL TRANSPORTATION BENEFIT** | 50% of Initial Hospital Confinement Benefit |
| **EMERGENCY ROOM BENEFIT** | [$250, $500] |
| **INITIAL HOSPITAL CONFINEMENT BENEFIT** | [$250 - $2,500(in $50 increments)] per Day |
| **BENEFIT PERIOD** | [2, 5,10] Days |
| **HOSPITAL CONFINEMENT BENEFIT** | [$100, $250, $500] per Day |
| **MAXIMUM NUMBER OF DAYS** | [365] Days |
| **WELL NEWBORN BENEFIT** | SEE PROVISION |
| **INTENSIVE CARE UNIT BENEFIT** | SEE PROVISION |
| **OUTPATIENT SURGERY BENEFIT** | $500 Per Covered Person, Per Calendar Year |
| **OUTPATIENT DIAGNOSTIC IMAGING BENEFIT** | $250 Per Covered Person, Per Calendar Year |
| **CONVALESCENT/SKILLED NURSING FACILITY CONFINEMENT** | $100 per Day |
| **HOME HEALTHCARE BENEFIT** | $50 per Day |
| **DEATH BENEFIT** | $10,000 |

**OPTIONAL COVERAGE:**

| | BENEFIT AMOUNT |
|---|---|
| **CRITICAL ILLNESS BENEFIT RIDER**…….. | [$5,000; $10,000] |

| | MAXIMUM BENEFIT |
|---|---|
| **DIAGNOSTIC IMAGING BENEFIT AND ACCIDENT RIDER**……. | [$2,000 OR $3,500] |

| | BENEFIT OPTION | MAXIMUM CALENDAR YEAR BENEFIT |
|---|---|---|
| **OUTPATIENT SURGERY BENEFIT RIDER**…… | [A or B] | [$5,000; $10,000] |

**POLICY NUMBER** - xxxxxxxxxxxx
**EFFECTIVE DATE** - August 1, 2011

| COVERED PERSONS | RELATIONSHIP | AGE | DATE OF BIRTH |
|---|---|---|---|
| JJ ANICO | POLICYHOLDER | 31 | 04/22/1980 |
| GG ANICO | SPOUSE | 24 | 04/16/1986 |

**TABLE OF CONTENTS**

## PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to Your first Policy anniversary, unless coverage changes. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 60 days notice before any premium change.

## DEFINITIONS

**BODILY INJURY** is the unforeseen, unexpected, unanticipated result of an act or event that causes You to require medical treatment within 48 hours of such act or event.

**CALENDAR YEAR** means the twelve-month period that begins January 1 and ends December 31, each year.

**CLOSE RELATIVE** means anyone related to You by blood, marriage, or adoption; or a court appointed representative.

**COMPLICATIONS OF PREGNANCY** means either of these two general types of conditions:

1. **TYPE I CONDITIONS:** The pregnancy does not end. The cause of the complication is distinct from the pregnancy. Examples include acute nephritis, nephrosis, and cardiac decompensation. There may be other similar conditions as well.

2. **TYPE II CONDITIONS**: The pregnancy ends. Any of the following may occur: delivery by Medically Necessary Cesarean section, ending of ectopic pregnancy, or spontaneous ending of pregnancy that takes place when a live birth is not possible.

**THE FOLLOWING CONDITIONS ARE NOT COMPLICATIONS OF PREGNANCY:** false labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage. We will not consider such a condition as a Complication of Pregnancy.

**CONVALESCENT/FACILITY SKILLED NURSING FACILITY** is a facility accredited by Medicare as a facility capable of providing 24 hour skilled nursing service and the following services: physical, occupational, speech and respiratory therapy. This facility may also be a ward, floor or other area contained within a Hospital and for which the primary purpose is skilled nursing care. Its main purpose must not be to provide custodial care, educational care, or rest care for the aged or treatment such as that provided by a clinic or drug alcohol rehabilitation center.

**COVERED PERSON** means each person named as a Covered Person on the Policy Schedule whose coverage under this Policy has not terminated.

**DIAGNOSTIC IMAGING** means Magnetic Resonance Imaging (**MRI**), Magnetic Resonance Angiography (**MRA**), Computed Axial Tomography (**CAT** Scans), Positron Emission Tomography (**PET** Scans), or Computed Tomography (**CT** scans).

**DOCTOR** means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under this Policy, and acting within the scope of that license.

**EFFECTIVE DATE** means the date, shown in Your Policy Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Effective Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

**EMERGENCY** means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. placing the Covered Persons health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

**EMERGENCY ROOM (ER)** means the department of a Hospital responsible for the provision of medical and surgical care to patients arriving at the Hospital in need of immediate Emergency care.

**HOSPITAL** means an institution that:
1. operates as a Hospital pursuant to law;
2. operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
3. provides 24-hour nursing service by Registered Nurses on duty or on call;
4. has a staff of one or more Physicians available at all times;
5. provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following whether free-standing or a section of another facility: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial or educational care; (c) facilities primarily affording rehabilitative care; or (d) facilities for the aged, drug addicts or alcoholics.

**HOSPITAL CONFINED** means that a Covered Person is admitted to a Hospital as an overnight resident bed patient. This term does not relate to a Covered Person's treatment in a Same Day Surgery facility, Emergency room, an observation room, or confinement in a Rehabilitation Facility.

**HOSPITAL STAY** means the period of time, measured in days from the date of Hospital Admission to the date of discharge, a Covered Person is Hospital Confined. For purposes of calculating benefits, successive Hospital Stays for the same or related causes, separated by 180 days or less, during which no Hospital Confinement occurs, will be treated as a single Hospital Stay.

**INJURY** (Injured) means accidental Bodily Injury sustained by the Covered Person which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under this Policy is in force.

**INTENSIVE CARE UNIT (INCLUDING CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT)** means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

**LIMITING AGE** for Your children is age 26.

**MEDICAL TRANSPORTATION** means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. Transportation by a common carrier is not covered.

**MEDICALLY NECESSARY** means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:
1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**MENTAL DISORDER** means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

**POLICYHOLDER** means You, the Applicant named in the attached Application, any successor thereof, or any person named to assume ownership privileges under this Policy after the original Policyholders death. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

**PREEXISTING CONDITION** means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 12 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 12 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 12 months of coverage.

**REHABILITATION FACILITY** means a specialized section of a Hospital or a properly licensed free standing facility that provides services under the direction of a Doctor that are rehabilitative or restorative; and are consistent with the standards of practice for rehabilitative medicine.

**SURGERY FACILITY** means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term “Same Day Surgery Facility” does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor’s office or Clinic.

**SICKNESS** means a Covered Person’s illness, disease, or condition that begins after the Effective Date and while such Covered Person has coverage under this Policy. Sickness also includes an illness, disease or condition that begins before the Effective Date if it is shown on the Covered Person’s Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while this Policy’s coverage in effect for the Covered Person.

**US, WE, OUR or THE COMPANY** means American National Life Insurance Company of Texas (ANTEX).

**YOU or YOUR** means the Applicant, named in the attached Application.

## BENEFIT

In order for the Company to pay any benefit, described below, the following conditions must be met:
1. The described benefit service must begin after the Covered Person’s Effective Date;
2. The described benefit service must be for the Medically Necessary treatment of a Covered Person’s Injury or Sickness; and
3. The described benefit service must begin and continue while the Covered Person’s coverage remains in effect under this Policy.

**MEDICAL TRANSPORTATION BENEFIT** – If a Covered Person requires Medical Transportation, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each trip, up to 2 trips per Covered Person, per Calendar Year.

**EMERGENCY ROOM (ER) BENEFIT** – If a Covered Person receives treatment in a Hospital Emergency room, We will pay the Emergency Room Benefit, shown on the Policy Schedule. Payment of this benefit is limited to 2 ER treatment visits per Covered Person, per Calendar Year.

**INITIAL HOSPITAL CONFINEMENT BENEFIT -** The Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital Confined. This Benefit is payable from the Covered Person’s first day of Hospital Confinement for the Benefit Period for this benefit, shown in Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

**HOSPITAL CONFINEMENT BENEFIT –** After expiration of the Initial Hospital Confinement Benefit Period, the Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital Confined, up to the Maximum Number of Days for any one Hospital Stay shown on Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

**HOSPITAL CONFINEMENT OF A WELL NEWBORN BENEFIT –** The Company will pay the same benefit amount as stated above under the INITIAL HOSPITAL CONFINEMENT BENEFIT and HOSPITAL CONFINEMENT BENEFIT, except that the number of days of confinement is limited to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

**INTENSIVE CARE UNIT BENEFIT -** The Company will pay [2] times the amount otherwise payable under the applicable Hospital Confinement Benefit when a Covered Person is confined in an Intensive Care Unit up to a maximum of [30] days for any one Hospital Stay.

**OUTPATIENT SURGERY BENEFIT -** If a Covered Person has surgery performed in a Surgery Facility and is not Hospital Confined at the time of the Surgery, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule.

**OUTPATIENT DIAGNOSTIC IMAGING BENEFIT -** If a Covered Person has Diagnostic Imaging performed and is not Hospital Confined at the time of such procedure, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule.

**CONVALESCENT/SKILLED NURSING FACILITY (CSNF) CONFINEMENT BENEFIT -** If a Covered Person is admitted to a CSNF immediately following a covered Hospital Confinement of at least one day, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they remain in the CSNF, up to a maximum 30 days per Calendar year. However, if benefits are also payable under the **HOME HEALTH CARE BENEFIT**, the 30 days, otherwise available under this benefit are reduced by the total number of days for which Home Health Benefits are paid.

**HOME HEALTH CARE BENEFIT -** If a Covered Person receives Home Health Care immediately following a covered Hospital Confinement or CSNF confinement of at least 3 days, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they receive Home Health Care, up to a maximum 30 days per Calendar year. However, if benefits are also payable under the **CSNF BENEFIT**, the 30 days, otherwise available under this benefit are reduced by the total number of days for which CSNF Benefits are paid.

**DEATH BENEFIT** – We will pay the Death Benefit shown on the Policy Schedule if You die as the result of an Injury You sustain while You are covered under this Policy. In order for the Benefit to be paid, Your death must occur within 100 days of the Injury. This benefit will be paid to the Beneficiary named in Your application, if living. Otherwise, this benefit is payable to Your estate.

**LOSS OF SIGHT OR LIMBS –** If You sustain a loss described in the following table while You are covered under this Policy, We will pay the respective Benefit shown in the table. Loss of a hand or foot means the complete severance of the hand or foot, at or above the wrist or ankle. Loss of sight means the total, permanent, and irreversible loss of sight with no expectation of recovery. The inability to see while You are in a coma is NOT "Loss of Sight" under this Rider and no benefit is payable.

| **LOSS** | **BENEFIT** |
|---|---|
| **LOSS OF BOTH HANDS** | **DEATH BENEFIT** |
| **LOSS OF BOTH FEET** | **DEATH BENEFIT** |
| **LOSS OF SIGHT OF BOTH EYES** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND AND ONE FOOT** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND AND SIGHT OF ONE EYE** | **DEATH BENEFIT** |
| **LOSS OF ONE FOOT AND SIGHT OF ONE EYE** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND** | **½ DEATH BENEFIT** |
| **LOSS OF ONE FOOT** | **½ DEATH BENEFIT** |

## EXCEPTIONS

**THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EXCEPTED EVENTS.**

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:

   a) To correct damage for a covered Injury or Sickness;
   b) To repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c) For reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in this Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.

13. Treatment provided outside the United States of America, its possessions and territories.

14. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

15. Treatment of alcoholism or drug use.

## AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

A child born to or adopted by You will become a Covered Person under this Policy.

**Newborns:** Coverage for newborn children is free for the first 90 days from the date of birth.

**Adopted Children:** Coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. The coverage is free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of this Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

## TERMINATION OF COVERAGE

We can terminate coverage under this Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of this Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
3. A Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY**.

## LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Policy Schedule and occurs on such date next following the date of the event that causes such termination.

**RULES FOR ALL COVERED PERSONS** - Coverage will end:

1. If this Policy is terminated in accordance with the section titled TERMINATION OF COVERAGE; or
2. If You fail to pay the required premium within the Grace Period.

**RULES FOR ADULT COVERED PERSONS** - Coverage will end:

1. For Your spouse if there is a divorce; or
2. For a mentally or physically disabled Covered Person if he/she marries or becomes capable of self-support;

If You are married and die and Your spouse is a Covered Person, Your spouse will become the Policyholder.
**RULES FOR CHILD COVERED PERSONS** - Coverage will end for a child when:

1. The child is no longer a dependent of Yours;
2. The child gets married;
3. The child attains the Limiting Age, except for the extension allowed by the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN; or
4. Neither You nor Your spouse remains covered under this Policy.

**PREMIUM** – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

## EXTENSION OF COVERAGE FOR SOME CHILDREN

When a dependent child who is a Covered Person that has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of self-sustaining employment, by reason of mental or physical handicap, and is chiefly dependent upon You for support and maintenance. The child will continue as a Covered Person if, in response to Our inquiry, You submit written proof of the child's incapacity and pay the premium for the child. The premium will be on the same basis as that for an adult of like age and sex. Extension of coverage will not continue for any child named in the Enrollment Application whose disabling condition existed prior to the Effective Date of such child's coverage and was not disclosed in the Enrollment Application:

## CONVERSION PRIVILEGE

If coverage under this Policy has been terminated, Covered Persons may be entitled to have a conversion policy issued by ANTEX that provides coverage similar to this Policy, without evidence of insurability, subject to the following terms and conditions.

A conversion policy is not available to a Covered Person if termination of his insurance under this Policy occurs:

1. Because he/she failed to make timely payment of any required premium; or
2. For any other reason, and he had not been continuously covered under this Policy, and for similar benefits under any policy which it replaced, during the entire three (3) months period ending with such termination; or
3. Because this Policy terminated and the insurance was replaced by similar coverage under another policy within thirty-one (31) days of the date of termination; and
4. Written application and the first premium payment for the conversion policy shall be made to ANTEX not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with ANTEX's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of ANTEX, a separate conversion policy may be issued to cover any dependent.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

## GENERAL PROVISIONS

**ENTIRE CONTRACT --** The Entire Contract will consist of:

1. This Policy;
2. Your Application and attached papers; and
3. Any riders, endorsements or amendments issued with or added to this Policy.

We will deem all the statements provided in any attached Application and attached supplements, except fraudulent statements, as representations and not warranties.

**TIME LIMIT ON CERTAIN DEFENSES --**

**1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION** --
After 1 year from the date a Covered Person becomes insured under this Policy, We may only use fraudulent misstatements in the Enrollment Application to void coverage under this Policy or to deny any claim for loss incurred after such 1 year period.

**2. PRE-EXISTING CONDITIONS** --
No claim for loss incurred after 12 months from the Effective Date will be reduced or denied because a Sickness or Injury, not excluded by name or specific description before the date of loss, existed 12 months before the Effective Date.

**REINSTATEMENT** -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45$^{th}$ day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

**WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER YOUR COVERAGE UNDER THIS POLICY HAS TERMINATED.**

**GRACE PERIOD** -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid.

**NOTICE OF CLAIMS** -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Policy Number.

**CLAIM FORMS --** When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

**PROOFS OF LOSS** -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

**TIME FOR PAYMENT OF CLAIMS --** All benefits payable under this Policy will be paid upon Our receipt of Proof of Loss.

**PAYMENT OF CLAIMS --** We will pay Policy benefits to You. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

**NO ASSUMPTION OF LIABILITY --** Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

**PHYSICAL EXAMINATIONS** -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

**LEGAL ACTIONS** -- No legal action may be brought to recover on this Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time this Policy requires written proof of loss.

**LIMITATION OF LIABILITY** -- You agree that Our maximum liability under this Policy and related matters is limited to:

1. Policy benefits otherwise payable;
2. Your reasonable attorneys fees, if any; and
3. Any statutory penalties that may be imposed.

**MISSTATEMENTS OF AGE** -- If a Covered Person has misstated his age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Effective Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

**CONFORMITY WITH STATE STATUTES** -- Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the state in which You reside is amended to conform to the minimum requirements of the laws of such state.

**ILLEGAL OCCUPATION** -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

**REFUND OF PREMIUM AT DEATH** – If the Policy is in force when You die, coverage will end and the pro rata unearned portion of any premium paid will be refunded. Unearned premiums will be paid in a lump sum no later than thirty (30) days after We receive proof of Your death.

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**

# HOSPITAL CONFINEMENT INSURANCE POLICY

**THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS. OTHER ADDITIONAL BENEFITS DESCRIBED IN THIS POLICY ARE ALSO PROVIDED.**

# Application to
# American National Life Insurance Company of Texas • P.O. Box 696870 • San Antonio, Texas 78269

Please Print - Use Black Ink ☐ New Policy ☐ Reinstatement Existing #: _____ ☐ Change Existing #:_____

1. Special Requests: Mail Policy to Applicant: ☐ Yes ☐ No Requested Effective Date:_____

2. Please print the full name of all Proposed Insureds (use additional sheet and attach if needed).

| Last, First, Middle Initial | Occupation | Relationship | Sex M/F | Date of Birth | Age | Height | Weight | Social Security Number |
|---|---|---|---|---|---|---|---|---|
| 1. | | Applicant | | | | | | |
| 2. | | Spouse | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |

3. Home Address: _____City:_____State:_____Zip Code:_____

Home Phone: (____)_____Cellular: (____)_____Email Address:_____

I apply for:

4.

Base Plan Daily Benefit Amount: ☐ $ 100 ☐ $ 250 ☐ $ 500 AD&D Beneficiary:_____

Emergency Room Benefit: ☐ $ 250 ☐ $ 500 AD&D Beneficiary Relationship:_____

Increased Daily Benefit Period: ☐ 2 Days ☐ 5 Days ☐ 10 Days

Increased Daily Benefit Amount: ☐ $ 250 ☐ $ 500 ☐ $ 1,000 ☐ $ 1,500 ☐ $ 2,000 ☐ $ 2,500

Base Plan Annual Premium: _____

Optional Benefits:

Critical Illness Rider : ☐ $5,000 ☐ $10,000 _____

Critical Illness Beneficiary: _____ Relationship _____

Outpatient Surgical Rider: ☐ $5,000 ☐ $10,000 _____

Outpatient Diagnostic Imaging Rider: ☐ $2,000 ☐ $3,500 _____

Mode: ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly PAC ☐ List Bill Total Annual Premium: _____

Total Premium Collected with Application: _____

5. Does any Proposed Insured currently have more than one Medical Expense and/or Hospital Indemnity Policy with this or any other company)?..... ☐ Yes ☐ No

If Yes, please name company and give details in chart below:

| Plan Type | Company | To Be Replaced? | Plan Type | Company | To Be Replaced? |
|---|---|---|---|---|---|
| | | ☐ Yes ☐ No | | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No | | | ☐ Yes ☐ No |

## MEDICAL HISTORY AND RELATED INFORMATION

*This plan can not be issued to any person who answers "yes" to question 6, 7, 8, or 9. Do not apply for coverage for this person.*

6. Is any Proposed Insured or family member of the household an expectant mother or expectant father?..... ☐ Yes ☐ No

7. Within the past 2 years, has any Proposed Insured had symptoms, treatment, or been recommended to have treatment for: Alcohol or Drug Abuse, Alzheimer's, Internal Cancer, COPD, Connective Tissue Disorder, Crohn's Disease, Ulcerative Colitis, Cystic Fibrosis, Dementia, Insulin Dependent Diabetes, Emphysema, Heart Attack, Heart Disease, Heart Bypass, Heart Stents, Hepatitis, Cirrhosis of the Liver, Hodgkins Disease, End Stage Renal Disease, Leukemia, Lupus Erythematosus, Multiple Sclerosis, Muscular Dystrophy, Organ Transplant (except corneal), Parkinson's Disease, Paralysis, Peripheral Vascular Disease, Stroke, TIA or Amyotrophic Lateral Sclerosis (ALS)?..... ☐ Yes ☐ No

8. Has any Proposed Insured been diagnosed by a physician, or tested positive or treated for HIV, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other Immune Disorder?..... ☐ Yes ☐ No

9. Has any Proposed Insured been advised to be admitted to a hospital, nursing home, clinic, or other institution for diagnosis or treatment, or had surgery or medical tests recommended, but not yet performed?..... ☐ Yes ☐ No

## MEDICAL HISTORY AND RELATED INFORMATION ***continued***

10. Has any Proposed Insured ever been declined, restricted, rated-up, or postponed for any kind of life or health insurance with this or any other company? ☐ Yes ☐ No
    If Yes, give details: _____
11. Has the Applicant used any form of tobacco within the past 12 months? ☐ Yes ☐ No
    Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months? ☐ Yes ☐ No
12. Has any Proposed Insured within the past 2 years, taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing(any type), motorcycle riding, professional sports, piloting aircraft(any type), or rodeo events? ☐ Yes ☐ No
    If Yes, indicate actvity and give details: _____
13. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's, or been arrested within the past 2 years? ☐ Yes ☐ No
    If Yes, give details and provide Driver's License # and state of issue: _____
14. Has any Proposed Insured received medical counseling, been treated in an emergency room or urgent care center, been admitted to any hospital, nursing home, clinic, or other institution for diagnosis or treatment within the past 2 years? ☐ Yes ☐ No
15. Has any Proposed Insured taken a medication recommended or prescribed by a Physician in the past 12 months? ☐ Yes ☐ No
16. Has any Proposed Insured had symptoms of, or been treated for, any of the following within the past 2 years:

| | | | |
|---|---|---|---|
| ☐ Chest Pain | ☐ Lung/Respiratory | ☐ Intestines or Colon | ☐ Mental or Nervous Disorder |
| ☐ Joints/Knees/Spine | ☐ Reproductive Organs | ☐ Kidneys | |
| ☐ Hernia | ☐ Gallbladder | ☐ Liver | |
| ☐ Prostate Disorder | ☐ Urinary Tract | ☐ Pancreas | |

Give full details below of all "Yes" answers to questions 14-16, include all dates, names and addresses of hospitals and all Physicians, nature of the condition or impairment, the treatment or advice given, and if released from the treatment (use additional sheet and attach if needed).

| Question Number | Proposed Insured | Date of Treatment Begin | - End | Reason for Condition Diagnosis, Injury, etc. | Degree of Recovery | Name/Address of Attending Physicians Street, City, State |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

## APPLICATION DECLARATION AND AGREEMENTS

ATTENTION — After this application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I have received *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare.

FRAUD WARNING — Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, submits an application for insurance or makes a claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information may be guilty of a felony.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned represents that the answers and statements on this application are true, complete, and correctly recorded; and agree they will be used to determine each Proposed Insured's eligibility for coverage under the health insurance plan requested hereby. I understand and agree that: 1. all statements and answers in this application and in any supplements or amendments to it are complete and true; 2. any incorrect or incomplete information on this application may result in loss of coverage or claim denial; 3. no insurance shall take effect unless a policy is issued (or this application is made to change or reinstate an existing policy, unless the change is approved) and actually delivered to the Applicant and the first full premium paid during the lifetime and continued health of all Proposed Insureds as represented in this application. I will notify and provide the Company with any evidence required by it to determine my future eligibility under the policy issued.

If this application is taken over the telephone or electronically, I agree that my electronic signature serves as my original signature.

I understand and agree that:

1. eligibility for the Plan does not constitute initial coverage under the Plan; and
2. initial coverage under the Plan is subject to the Company's criteria.

Signed at _____ _____
City State Zip Code Date

_____ _____
Applicant's Signature Spouse's Signature (if coverage is requested for spouse)

Agent Name: _____ ANTEX Writing Number: _____

Fax Number: _____ Email Address: _____

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the MIG, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured. It is understood that AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:
1. Such information will be used by AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3. A picture copy or photocopy of this authorization shall be as valid as the original; and
4. I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

_____ Signed at City and State

_____ Applicant's Signature

_____ Date

_____ Spouse's Signature (if coverage is requested for spouse)

_____ Witness

_____ Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one)power of attorney, guardian-in-fact, guardian, payee representative or other_____.

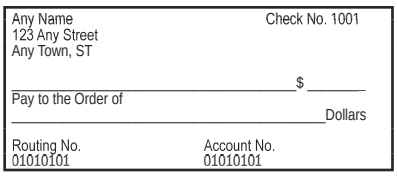
## BILLING INFORMATION

Payment Mode: ☐ Annual ☐ Semi-Annual
☐ Quarterly ☐ Monthly Electronic Debit

☐ Cash collected with Application $_____ ☐ Draft Initial Premium $_____

Monthly Electronic Withdrawals
Desired withdrawal date (1-28) _____ ☐ Checking ☐ Savings

*(Funds to be withdrawn from the account number shown on a CWA, otherwise, submit a copy of a voided check or deposit slip to establish a different account for premium withdrawal.)*


Any Name
123 Any Street
Any Town, ST
Check No. 1001
$ _____
Pay to the Order of
Dollars
Routing No. 01010101
Account No. 01010101

Bank Name:_____

City:_____ State:_____

Routing Number:_____ Account Number: _____

Credit Card Information
*Credit Card Payment for Initial Premium Only.* Payment Amount $_____ ☐ VISA ☐ Mastercard ☐ Discover Card

Credit Card Number:_____ Expiration Date:_____

Three Digit Code on Back of Card: _____ Print Name of Cardholder: _____

Billing Address: _____ City: _____ State:____ Zip: _____

Cardholder Signature: _____ If Insurance Premium Payor is not Applicant please provide the following:

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone: (____)_____

## FAIR CREDIT REPORTING ACT (FCRA) PRE-NOTIFICATION

Federal and state law requires notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing proper identification, you may inspect or receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of you family, employers or business associates, financial sources, friends, neighbors or other with whom you are acquainted. The information will consist, when applicable, of a confirmation or your identity, age, residence, marital status and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.

## MEDICAL INFORMATION BUREAU (MIB) PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. American National Life Insurance Company of Texas, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Life Insurance Company of Texas, or its reinsurers, may also release information in its file to other insurance companies to who you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

THIS PAGE IS TO BE LEFT WITH THE APPLICANT AT THE POINT OF SALE

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**
**(referred hereafter as "We", "Our", "Us" or "the Company")**

# HOSPITAL CONFINEMENT INSURANCE POLICY
# OUTLINE OF COVERAGE
# POLICY FORM SERIES ANL-HOPS11

**Coverage provided by the Policy is Hospital Confinement Insurance and it provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.**

1. Read your Policy carefully. This Outline of Coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual Policy provisions control. The Policy itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Hospital Confinement coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalizations resulting from a covered accident or sickness, subject to any limitations set forth in the Policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits described below.

3. **BENEFITS**

| **BENEFIT** | **BENEFIT AMOUNT** |
|---|---|
| Medical Transport Benefit…….... | 50% of initial Hospital Confinement Benefit |
| Emergency Room Benefit…… | [$250 or $500] |
| Initial Hospital Confinement Benefit…… | [$250-$2,500 (in $50 increments)] per Day |
| Benefit Period…… | [2, 5, 10] Days |
| Hospital Confinement Benefit…….. | [$100, $250, $500] per Day |
| Maximum Number of Days…….. | 365 Days |
| Well Newborn Benefit…… | See Policy Provision |
| Intensive Care Unit Benefit…….. | See Policy Provision |
| Outpatient Surgery Benefit…… | $500 per Covered Person per Calendar Year |
| Outpatient Diagnostic Imaging Benefit…… | $250 per Covered Person per Calendar Year |
| Convalescent/Skilled Nursing Facility Confinement……. | $100 per Day |
| Home Health Care Benefit…… | $50 per Day |
| Death Benefit…….. | $10,000 |
| Loss of Sight or Limbs…….. | See Policy Provision |

4. **EXCEPTIONS, LIMITATIONS AND REDUCTIONS**

**A. EXCEPTIONS**

**THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EVENTS.**

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace or remove breast implants; however, this Exception does not apply when surgery is required:

   a. to correct damage for a covered Injury or Sickness;
   b. to repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c. for reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in the Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous or morbid obesity.

13. Treatment provided outside the United States of America, its possessions and territories.

14. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

15. Treatment of alcohol or drug use.

**B. LIMITATIONS**

1. The Company may reduce or deny a claim or void the Policy until such Policy has been in effect for one year, if you make an omission or misrepresentation of material fact in the application for the Policy;

2. The Company may deny or void the Policy at any time if you made a fraudulent material misrepresentation in the application for the Policy.

**PREEXISTING CONDITION** means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 12 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 12 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 12 months of coverage.

5. **RENEWABILITY**

We can terminate coverage under the Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments;

2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of the Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under the Policy's General Provisions; or

3. A Covered Person ceases to be eligible for continued coverage under the Policy as described in the Section of the Policy titled **LOSS OF ELIGIBILITY**.

6. **PREMIUMS**

| | |
|---|---|
| **Initial Premium:** | **$**_____ As stated in Section 5, premiums are subject to change. |
| **Mode of Payment Selected:** | ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC |
| **Initial Modal Premium:** | $_____ |

The Policy has a 31-day Grace Period.

Premiums are subject to change.

**This Outline is a brief description of the Policy terms and provisions. Refer to the Policy for further details.**

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA GALVESTON, TEXAS 77550**

## CRITICAL ILLNESS BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is subject to all non-conflicting Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Policy Date

Benefits provided by this Rider are in addition to any similar benefits provided under the Policy or other Rider.

## DEFINITIONS

**CANCER** means a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue through the basement membrane or capsule. “Invasive Cancer” includes, but shall not be limited to any form of:

1. Leukemia;
2. Lymphoma; or
3. Multiple Myeloma

The following are not “Invasive Cancer”:

1. pre-malignant lesions (such as intraepithelial neoplasia); or
2. benign tumors or polyps; or
3. early prostate cancer Diagnosed as T1N0M0 or equivalent staging; or
4. Cancer in Situ; or
5. any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

Invasive Cancer must be Diagnosed by a Physician, board-certified as a pathologist pursuant to a Pathological or Clinical Diagnosis.

**CRITICAL ILLNESS** means Cancer(other than skin cancer, but including melanoma), Stroke(CVA), Heart Attack(Acute Myocardial Infarction), End Stage Renal Disease/Kidney Failure, or Major Organ Transplant first diagnosed for a Covered Person more than 10 days after his/her Rider Effective Date.

**END-STAGE RENAL DISEASE/KIDNEY FAILURE** means the chronic and irreversible failure of both of a Covered Person’s kidneys. The Diagnosis must be made by a Physician.

**HEART ATTACK** means an Acute Myocardial Infarction resulting in:

1. the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries; and
2. resulting in the loss of the normal function of the heart.

The Diagnosis must be made by a Physician and based on both:

1. new clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and
2. serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Established (old) Myocardial Infarction is excluded.

**MAJOR ORGAN** means a Covered Person’s entire liver, kidney, lung, heart, small intestine, pancreas, pancreas-kidney, bone marrow, or stem-cells. No other organ or system is included.

**MAJOR ORGAN TRANSPLANT** means the placement of an entire Major Organ in a Covered Person, where such Major Organ:

1. originates in a person other than such Covered Person;
2. is somewhat independent from all other parts of the human body; and
3. performs a special or unique function.

An Major Organ Transplant does not include the placement of a mechanical or man-made device or substance which is intended to serve as a substitute for or aid in the performance of the failed Major Organ; nor does it include Major Organ parts such as valves, ducts, arteries, and any other part of a Major Organ, which in and of itself provides no life sustaining purpose. For purposes of this definition, a Major Organ Transplant is considered to have occurred on the date a Covered Person is added to the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP) transplant list.

**STROKE** means any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. Transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded. The Diagnosis must be made by a Physician.

## BENEFIT

**CRITICAL ILLNESS BENEFIT -** When a Covered Person is first diagnosed with a Critical Illness; We will pay the Critical Illness Rider Benefit amount shown in his/her Policy Schedule. This benefit is payable only once for each Covered Person. In the event a Covered Person dies as the result of a Critical Illness without being Hospital Confined, the Rider Benefit will be paid to the Beneficiary named in the Application on the basis of post-mortem Critical Illness diagnosis.

Coverage under this Rider terminates for a Covered Person on the first to occur of:

1. the Covered Person's Death

2. payment of the Rider Benefit on behalf of the Covered Person; or

3. the date the Covered Person's coverage under the Policy terminates

Rider Effective Date, if other than Policy Date: _____

**Secretary**

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
**HOME OFFICE: ONE MOODY PLAZA**
**GALVESTON, TEXAS**

## DIAGNOSTIC IMAGING BENEFIT AND ACCIDENT RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is subject to all non-conflicting Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Policy Date.

Benefits provided by this Rider are in addition to any similar benefits provided under the Policy or other Rider.

### BENEFITS

**DIAGNOSTIC IMAGING BENEFIT** - We will pay benefits, as shown in the table below, for each Diagnostic Imaging procedure performed on a Covered Person, subject to the Calendar Year Maximum Benefit for this Diagnostic Imaging Benefit. The Calendar Year Maximum Benefit for each Covered Person is shown in the Policy Schedule.

| DIAGNOSTIC IMAGING TEST | BENEFIT |
|---|---|
| **PET** | **$1,500** |
| **MRA** | **$1,100** |
| **MRI** | **$800** |
| **CAT/CT** | **$575** |

**ACCIDENT BENEFIT -** If a Covered Person is Injured, We will pay 80% the actual charge incurred by a Covered Person for treatment of such Injury, in excess of $100. The Calendar Year maximum benefit payable under this provision for each Covered Person is $1,000.

Coverage under this Rider terminates for a Covered Person on the first to occur of:

1. his/her death; or
2. the date his/her coverage terminates under the Policy or this Rider.

Rider Effective Date, if other than Policy Date: _____

J. Mick Flippin

**Secretary**

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA GALVESTON, TEXAS 77550**

## OUTPATIENT SURGICAL PROCEDURE BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is subject to all non-conflicting Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Policy Date.

Benefits provided by this Rider are in addition any similar benefits provided under the Policy or other Rider.

## DEFINITIONS

**OUTPATIENT BASIS –** means that no hospital confinement occurred; nor was one intended for a covered Surgical Procedure; such Surgical Procedure having been performed in a Doctor's office, outpatient department of a Hospital, or free-standing outpatient Surgery Facility.

## BENEFIT

**SURGICAL PROCEDURE BENEFIT** – We will pay the Benefit for this Rider when a Covered Person has a Surgical Procedure performed on an Outpatient Basis. The amount of the benefit will be based upon the type of Surgical Procedure performed, its related identifier (CPT) Code, and the benefit option You have selected for this Rider, shown in the Policy Schedule. The Maximum Calendar Year Benefit for each Covered Person is also shown in the Policy Schedule

Below is a table of Surgical Procedures generally performed on an Outpatient Basis and the relative benefit for each. For Surgical Procedures not shown in the table, We will pay a benefit amount based upon the relative cost of the Surgical Procedure performed on the Covered Person, as provided in an insurance industry recognized publication of such relative costs.

## SURGICAL PROCEDURES

| | OPTION A | OPTION B |
|---|---|---|
| **REMOVAL OF 1.1- 2.0 CM MALIGNANT LESION ON ARM ……** | $130 | $260 |
| **REMOVE NAIL BED ……..** | $135 | $270 |
| **MOHS SURGERY FOR REMOVAL OF MALIGNANT LESION ……** | $370 | $740 |
| **BIOPSY OF BREAST, OPEN ……** | $210 | $420 |
| **EXCISION, BREAST LESION ……..** | $300 | $600 |
| **RECONSTRUCT SHOULDER JOINT ……** | $1,320 | $2,640 |
| **REPAIR OF HAMMERTOE ……...** | $290 | $580 |
| **BUNION REPAIR ……** | $540 | $1,080 |
| **ARTHROSCOPY OF KNEE WITH MENISCECTOMY ……** | $900 | $1,800 |
| **REMOVAL OF NASAL POLYPS ……** | $260 | $520 |
| **REPAIR OF NASAL SEPTUM ……..** | $750 | $1,500 |
| **BRONCHOSCOPY W/TUMOR EXCISION ……** | $373 | $745 |
| **INSERTION OF PACEMAKER ……** | $500 | $1,000 |
| **TONSILLECTOMY ……** | $280 | $560 |
| **UPPER GI ENDOSCOPY WITH BIOPSY ……..** | $255 | $510 |
| **COLONOSCOPY WITH POLYP REMOVAL ….** | $425 | $850 |

| | OPTION A | OPTION B |
|---|---|---|
| **REMOVE HEMORRHOIDS & FISTULA ……..** | $550 | $1,100 |
| **REMOVAL OF GALLBLADDER (LAPAROSCOPIC) ……..** | $750 | $1,500 |
| **REPAIR INGUINAL HERNIA, SLIDING ……..** | $520 | $1,040 |
| **LITHOTRIPSY (FRAGMENTING OF KIDNEY STONE) ……..** | $720 | $1,440 |
| **PROSTATECTOMY (TURP) ……..** | $780 | $1,560 |
| **BIOPSY OF PROSTATE (NEEDLE) ……..** | $125 | $250 |
| **REPAIR BLADDER & VAGINA ……..** | $400 | $800 |
| **CARPAL TUNNEL SURGERY ……..** | $430 | $860 |
| **CATARACT SURGERY, COMPLEX ……..** | $1,250 | $2,500 |
| **REPAIR DETACHED RETINA ……..** | $1,800 | $3,600 |
| **REVISE TWO EYE MUSCLES ……..** | $790 | $1,580 |
| **INSERTING TUBE IN EAR ……..** | $163 | $325 |

**NO BENEFITS ARE PAYABLE UNDER THIS RIDER FOR ANY SURGICAL PROCEDURE PERFORMED WHILE A COVERED PERSON IS HOSPITAL CONFINED.**

Coverage under this Rider terminates for a Covered Person on the first to occur of:

1. his/her death; or
2. the date his/her coverage terminates under the Policy or this Rider.

Rider Effective Date, if other than Policy Date: _____

**Secretary**


**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
Home Office: One Moody Plaza, Galveston, TX 77550
Mailing Address: P.O. BOX 696990, San Antonio, TX 78269
1-800-899-6805

# IMPORTANT NOTICE TO PERSONS ON MEDICARE
# THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

## THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance pays a fixed dollar amount regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

**This insurance duplicates Medicare benefits when it pays:**

- any expenses or services covered by the policy that are also covered by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- hospice
- other approved items and services

## BEFORE YOU BUY THIS INSURANCE

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or State Senior Health Insurance Program (SHIP).


**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
Home Office: One Moody Plaza, Galveston, TX 77550
Mailing Address: P.O. BOX 696990, San Antonio, TX 78269
1-800-899-6805

## NOTICE TO APPLICANT
## REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by American National Life Insurance Company of Texas. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under the present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding your proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. **Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been inforce.** After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

_____ _____

Date Applicant’s Signature

# CONSUMER INFORMATION NOTICE

**If you have questions about your policy or a claim you have filed, please contact your insurance company or your agent:**

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
C/O Customer Service Department
P.O. Box 696820
San Antonio, Texas 78269-6820

Telephone: 1-800-899-6805

**Agent:**_____

**Address:**_____

_____

**Telephone:**_____

If you are unable to resolve a problem with your insurance company or your agent, you may contact the Arkansas Department of Insurance:

**ARKANSAS INSURANCE DEPARTMENT**
**Consumer Services Division**
1200 West Third Street
Little Rock, AR 72201-1804

Telephone: 1-800-852-5494
1-501-371-2640

E-Mail: insurance@mail.state.ar.us
Web Site: www.state.ar.us/insurance

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Rate Information

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:** Neutral

**Overall Percentage of Last Rate Revision:** %

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

## Company Rate Information

| Company Name: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where required): | Minimum % Change (where required): |
|---|---|---|---|---|---|---|---|
| American National Life Insurance Company of Texas | 0.000% | 0.000% | $0 | 0 | $0 | 0.000% | 0.000% |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved-Closed | 08/19/2011 |

**Comments:**
COMPLIANCE CERTIFICATION IS ATTACHED.
**Attachment:**
READ - slaico.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Application | Approved-Closed | 08/19/2011 |
| **Bypass Reason:** | APPLICATON IS ATTACHED UNDER THE FORM SCHEDULE TAB | | |

**Comments:**

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Health - Actuarial Justification | Approved-Closed | 08/19/2011 |

**Comments:**
ACTUARIAL MEMORANDUM AND RATES
**Attachments:**
MEMO only.pdf
RATES only.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Outline of Coverage | Approved-Closed | 08/19/2011 |
| **Bypass Reason:** | THE OUTLINE OF COVERAGE IS ATTACHED UNDER THE FORM SCHEDULE | | |

**Comments:**

| | | Item Status: | Status Date: |
|---|---|---|---|

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

| | | | |
|---|---|---|---|
| **Satisfied - Item:** | red lined forms revised pursuant to Departmental objections | Approved-Closed | 08/19/2011 |

**Comments:**

red lined policy, outline of coverage and application

**Attachments:**

obj only redPolicy.pdf

red line application.pdf

redlined OUTLINE.pdf

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY
ONE MOODY PLAZA
GALVESTON, TEXAS

READABILITY CERTIFICATION

We hereby certify that form(s) ANL-HOPS11(AR), et. al. has (have) achieved a Flesch scale readability score that meets the minimum reading ease score as required by the state of Arkansas.

James P. Stelling
Vice President, Health Compliance

Date: August 12, 2011

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**

A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**

**HOSPITAL CONFINEMENT INSURANCE POLICY**

This Policy is a contract of insurance. **READ IT CAREFULLY.**

We pay benefits in accordance with all the terms and conditions of this Policy.

**IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION -** You should read Your Application and all documents attached to Your Policy. **Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

Your Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy.

We do not provide coverage until Your Application has been approved and Your Initial Premium is paid. The Initial Premium pays for Your Initial Term of coverage. Your Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Effective Date. Coverage is continued in accordance with all of the provisions of this Policy.

**30 DAY RIGHT TO EXAMINE THIS POLICY** – You may return this Policy to Us for any reason within 30 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Policy, coverage under this Policy is void from the beginning. We will refund any premium paid.

**GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER – SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL.** You have the right to continue this Policy in force subject to the termination provisions and Your continued payment of premium in accordance with all the provisions of this Policy.

**PREMIUMS ARE SUBJECT TO CHANGE -** Please refer to the section titled **PREMIUMS**.

**SECRETARY** **PRESIDENT**

**THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS. OTHER ADDITIONAL BENEFITS DESCRIBED IN THIS POLICY ARE ALSO PROVIDED.**

## POLICY SCHEDULE

| BENEFIT | BENEFIT AMOUNT |
|---|---|
| **MEDICAL TRANSPORTATION BENEFIT** | 50% of Initial Hospital Confinement Benefit |
| **EMERGENCY ROOM BENEFIT** | [$250, $500] |
| **INITIAL HOSPITAL CONFINEMENT BENEFIT** | [$250 - $2,500(in $50 increments)] per Day |
| **BENEFIT PERIOD** | [2, 5,10] Days |
| **HOSPITAL CONFINEMENT BENEFIT** | [$100, $250, $500] per Day |
| **MAXIMUM NUMBER OF DAYS** | [365] Days |
| **WELL NEWBORN BENEFIT** | SEE PROVISION |
| **INTENSIVE CARE UNIT BENEFIT** | SEE PROVISION |
| **OUTPATIENT SURGERY BENEFIT** | $500 Per Covered Person, Per Calendar Year |
| **OUTPATIENT DIAGNOSTIC IMAGING BENEFIT** | $250 Per Covered Person, Per Calendar Year |
| **CONVALESCENT/SKILLED NURSING FACILITY CONFINEMENT** | $100 per Day |
| **HOME HEALTHCARE BENEFIT** | $50 per Day |
| **DEATH BENEFIT** | $10,000 |

**OPTIONAL COVERAGE:**

| | BENEFIT AMOUNT |
|---|---|
| **CRITICAL ILLNESS BENEFIT RIDER**…….. | [$5,000; $10,000] |

| | MAXIMUM BENEFIT |
|---|---|
| **DIAGNOSTIC IMAGING BENEFIT AND ACCIDENT RIDER**……. | [$2,000 OR $3,500] |

| | BENEFIT OPTION | MAXIMUM CALENDAR YEAR BENEFIT |
|---|---|---|
| **OUTPATIENT SURGERY BENEFIT RIDER**…… | [A or B] | [$5,000; $10,000] |

**POLICY NUMBER** - xxxxxxxxxxxx
**EFFECTIVE DATE** - August 1, 2011

| COVERED PERSONS | RELATIONSHIP | AGE | DATE OF BIRTH |
|---|---|---|---|
| JJ ANICO | POLICYHOLDER | 31 | 04/22/1980 |
| GG ANICO | SPOUSE | 24 | 04/16/1986 |

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## PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to Your first Policy anniversary, unless coverage changes. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 60 days notice before any premium change.

## DEFINITIONS

**BODILY INJURY** is the unforeseen, unexpected, unanticipated result of an act or event that causes You to require medical treatment within 48 hours of such act or event.

**CALENDAR YEAR** means the twelve-month period that begins January 1 and ends December 31, each year.

**CLOSE RELATIVE** means anyone related to You by blood, marriage, or adoption; or a court appointed representative.

**COMPLICATIONS OF PREGNANCY** means either of these two general types of conditions:

1. **TYPE I CONDITIONS:** The pregnancy does not end. The cause of the complication is distinct from the pregnancy. Examples include acute nephritis, nephrosis, and cardiac decompensation. There may be other similar conditions as well.

2. **TYPE II CONDITIONS**: The pregnancy ends. Any of the following may occur: delivery by Medically Necessary Cesarean section, ending of ectopic pregnancy, or spontaneous ending of pregnancy that takes place when a live birth is not possible.

**THE FOLLOWING CONDITIONS ARE NOT COMPLICATIONS OF PREGNANCY:** false labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage. We will not consider such a condition as a Complication of Pregnancy.

**CONVALESCENT/FACILITY SKILLED NURSING FACILITY** is a facility accredited by Medicare as a facility capable of providing 24 hour skilled nursing service and the following services: physical, occupational, speech and respiratory therapy. This facility may also be a ward, floor or other area contained within a Hospital and for which the primary purpose is skilled nursing care. Its main purpose must not be to provide custodial care, educational care, or rest care for the aged or treatment such as that provided by a clinic or drug alcohol rehabilitation center.

**COVERED PERSON** means each person named as a Covered Person on the Policy Schedule whose coverage under this Policy has not terminated.

**DIAGNOSTIC IMAGING** means Magnetic Resonance Imaging (**MRI**), Magnetic Resonance Angiography (**MRA**), Computed Axial Tomography (**CAT** Scans), Positron Emission Tomography (**PET** Scans), or Computed Tomography (**CT** scans).

**DOCTOR** means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under this Policy, and acting within the scope of that license.

**EFFECTIVE DATE** means the date, shown in Your Policy Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Effective Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

**EMERGENCY** means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. placing the Covered Persons health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

**EMERGENCY ROOM (ER)** means the department of a Hospital responsible for the provision of medical and surgical care to patients arriving at the Hospital in need of immediate Emergency care.

**HOSPITAL** means an institution that:
1. operates as a Hospital pursuant to law;
2. operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
3. provides 24-hour nursing service by Registered Nurses on duty or on call;
4. has a staff of one or more Physicians available at all times;
5. provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following whether free-standing or a section of another facility: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial or educational care; (c) facilities primarily affording rehabilitative care; or (d) facilities for the aged, drug addicts or alcoholics.

**HOSPITAL CONFINED** means that a Covered Person is admitted to a Hospital as an overnight resident bed patient. This term does not relate to a Covered Person's treatment in a Same Day Surgery facility, Emergency room, an observation room, or confinement in a Rehabilitation Facility.

**HOSPITAL STAY** means the period of time, measured in days from the date of Hospital Admission to the date of discharge, a Covered Person is Hospital Confined. For purposes of calculating benefits, successive Hospital Stays for the same or related causes, separated by 180 days or less, during which no Hospital Confinement occurs, will be treated as a single Hospital Stay.

**INJURY** (Injured) means accidental Bodily Injury sustained by the Covered Person which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under this Policy is in force.

**INTENSIVE CARE UNIT (INCLUDING CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT)** means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

**LIMITING AGE** for Your children is age 26.

**MEDICAL TRANSPORTATION** means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. Transportation by a common carrier is not covered.

**MEDICALLY NECESSARY** means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:
1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**MENTAL DISORDER** means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

**POLICYHOLDER** means You, the Applicant named in the attached Application, any successor thereof, or any person named to assume ownership privileges under this Policy after the original Policyholders death. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

**PREEXISTING CONDITION** means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 12 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 12 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 12 months of coverage.

**REHABILITATION FACILITY** means a specialized section of a Hospital or a properly licensed free standing facility that provides services under the direction of a Doctor that are rehabilitative or restorative; and are consistent with the standards of practice for rehabilitative medicine.

**SURGERY FACILITY** means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term “Same Day Surgery Facility” does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor’s office or Clinic.

**SICKNESS** means a Covered Person’s illness, disease, or condition that begins after the Effective Date and while such Covered Person has coverage under this Policy. Sickness also includes an illness, disease or condition that begins before the Effective Date if it is shown on the Covered Person’s Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while this Policy’s coverage in effect for the Covered Person.

**US, WE, OUR or THE COMPANY** means American National Life Insurance Company of Texas (ANTEX).

**YOU or YOUR** means the Applicant, named in the attached Application.

## BENEFIT

In order for the Company to pay any benefit, described below, the following conditions must be met:
1. The described benefit service must begin after the Covered Person’s Effective Date;
2. The described benefit service must be for the Medically Necessary treatment of a Covered Person’s Injury or Sickness; and
3. The described benefit service must begin and continue while the Covered Person’s coverage remains in effect under this Policy.

**MEDICAL TRANSPORTATION BENEFIT** – If a Covered Person requires Medical Transportation, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each trip, up to 2 trips per Covered Person, per Calendar Year.

**EMERGENCY ROOM (ER) BENEFIT** – If a Covered Person receives treatment in a Hospital Emergency room, We will pay the Emergency Room Benefit, shown on the Policy Schedule. Payment of this benefit is limited to 2 ER treatment visits per Covered Person, per Calendar Year.

**INITIAL HOSPITAL CONFINEMENT BENEFIT -** The Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital Confined. This Benefit is payable from the Covered Person’s first day of Hospital Confinement for the Benefit Period for this benefit, shown in Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

**HOSPITAL CONFINEMENT BENEFIT –** After expiration of the Initial Hospital Confinement Benefit Period, the Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital Confined, up to the Maximum Number of Days for any one Hospital Stay shown on Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

**HOSPITAL CONFINEMENT OF A WELL NEWBORN BENEFIT –** The Company will pay the same benefit amount as stated above under the INITIAL HOSPITAL CONFINEMENT BENEFIT and HOSPITAL CONFINEMENT BENEFIT, except that the number of days of confinement is limited to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

**INTENSIVE CARE UNIT BENEFIT -** The Company will pay [2] times the amount otherwise payable under the applicable Hospital Confinement Benefit when a Covered Person is confined in an Intensive Care Unit up to a maximum of [30] days for any one Hospital Stay.

**OUTPATIENT SURGERY BENEFIT -** If a Covered Person has surgery performed in a Surgery Facility and is not Hospital Confined at the time of the Surgery, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule.

**OUTPATIENT DIAGNOSTIC IMAGING BENEFIT -** If a Covered Person has Diagnostic Imaging performed and is not Hospital Confined at the time of such procedure, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule.

**CONVALESCENT/SKILLED NURSING FACILITY (CSNF) CONFINEMENT BENEFIT -** If a Covered Person is admitted to a CSNF immediately following a covered Hospital Confinement of at least one day, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they remain in the CSNF, up to a maximum 30 days per Calendar year. However, if benefits are also payable under the **HOME HEALTH CARE BENEFIT**, the 30 days, otherwise available under this benefit are reduced by the total number of days for which Home Health Benefits are paid.

**HOME HEALTH CARE BENEFIT -** If a Covered Person receives Home Health Care immediately following a covered Hospital Confinement or CSNF confinement of at least 3 days, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they receive Home Health Care, up to a maximum 30 days per Calendar year. However, if benefits are also payable under the **CSNF BENEFIT**, the 30 days, otherwise available under this benefit are reduced by the total number of days for which CSNF Benefits are paid.

**DEATH BENEFIT** – We will pay the Death Benefit shown on the Policy Schedule if You die as the result of an Injury You sustain while You are covered under this Policy. In order for the Benefit to be paid, Your death must occur within 100 days of the Injury. This benefit will be paid to the Beneficiary named in Your application, if living. Otherwise, this benefit is payable to Your estate.

**LOSS OF SIGHT OR LIMBS –** If You sustain a loss described in the following table while You are covered under this Policy, We will pay the respective Benefit shown in the table. Loss of a hand or foot means the complete severance of the hand or foot, at or above the wrist or ankle. Loss of sight means the total, permanent, and irreversible loss of sight with no expectation of recovery. The inability to see while You are in a coma is NOT "Loss of Sight" under this Rider and no benefit is payable.

| LOSS | BENEFIT |
|---|---|
| **LOSS OF BOTH HANDS** | **DEATH BENEFIT** |
| **LOSS OF BOTH FEET** | **DEATH BENEFIT** |
| **LOSS OF SIGHT OF BOTH EYES** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND AND ONE FOOT** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND AND SIGHT OF ONE EYE** | **DEATH BENEFIT** |
| **LOSS OF ONE FOOT AND SIGHT OF ONE EYE** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND** | **½ DEATH BENEFIT** |
| **LOSS OF ONE FOOT** | **½ DEATH BENEFIT** |

## EXCEPTIONS

**THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EXCEPTED EVENTS.**

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:

   a) To correct damage for a covered Injury or Sickness;
   b) To repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c) For reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in this Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.

13. Treatment provided outside the United States of America, its possessions and territories.

~~14. Routine newborn care.~~

15. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

16. Treatment of alcoholism or drug use.

## AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

A child born to or adopted by You will become a Covered Person under this Policy.

**Newborns:** Coverage for newborn children is free for the first 90 days from the date of birth.

**Adopted Children:** Coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. The coverage is free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of this Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

## TERMINATION OF COVERAGE

We can terminate coverage under this Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of this Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
3. A Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY**.

## LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Policy Schedule and occurs on such date next following the date of the event that causes such termination.

**RULES FOR ALL COVERED PERSONS** - Coverage will end:

1. If this Policy is terminated in accordance with the section titled TERMINATION OF COVERAGE; or
2. If You fail to pay the required premium within the Grace Period.

**RULES FOR ADULT COVERED PERSONS** - Coverage will end:

1. For Your spouse if there is a divorce; or
2. For a mentally or physically disabled Covered Person if he/she marries or becomes capable of self-support;

If You are married and die and Your spouse is a Covered Person, Your spouse will become the Policyholder.
**RULES FOR CHILD COVERED PERSONS** - Coverage will end for a child when:

1. The child is no longer a dependent of Yours;
2. The child gets married;
3. The child attains the Limiting Age, except for the extension allowed by the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN; or
4. Neither You nor Your spouse remains covered under this Policy.

**PREMIUM** – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

## EXTENSION OF COVERAGE FOR SOME CHILDREN

When a dependent child who is a Covered Person that has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of self-sustaining employment, by reason of mental or physical handicap, and is chiefly dependent upon You for support and maintenance. The child will continue as a Covered Person if, in response to Our inquiry, You submit written proof of the child's incapacity and pay the premium for the child. The premium will be on the same basis as that for an adult of like age and sex. Extension of coverage will not continue for any child named in the Enrollment Application whose disabling condition existed prior to the Effective Date of such child's coverage and was not disclosed in the Enrollment Application:

## CONVERSION PRIVILEGE

If coverage under this Policy has been terminated, Covered Persons may be entitled to have a conversion policy issued by ANTEX that provides coverage similar to this Policy, without evidence of insurability, subject to the following terms and conditions.

A conversion policy is not available to a Covered Person if termination of his insurance under this Policy occurs:

1. Because he/she failed to make timely payment of any required premium; or
2. For any other reason, and he had not been continuously covered under this Policy, and for similar benefits under any policy which it replaced, during the entire three (3) months period ending with such termination; or
3. Because this Policy terminated and the insurance was replaced by similar coverage under another policy within thirty-one (31) days of the date of termination; and
4. Written application and the first premium payment for the conversion policy shall be made to ANTEX not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with ANTEX's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of ANTEX, a separate conversion policy may be issued to cover any dependent.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

## GENERAL PROVISIONS

**ENTIRE CONTRACT --** The Entire Contract will consist of:

1. This Policy;
2. Your Application and attached papers; and
3. Any riders, endorsements or amendments issued with or added to this Policy.

We will deem all the statements provided in any attached Application and attached supplements, except fraudulent statements, as representations and not warranties.

**TIME LIMIT ON CERTAIN DEFENSES --**

**1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION** --
After 1 year from the date a Covered Person becomes insured under this Policy, We may only use fraudulent misstatements in the Enrollment Application to void coverage under this Policy or to deny any claim for loss incurred after such 1 year period.

**2. PRE-EXISTING CONDITIONS** --
No claim for loss incurred after 12 months from the Effective Date will be reduced or denied because a Sickness or Injury, not excluded by name or specific description before the date of loss, existed 12 months before the Effective Date.

**REINSTATEMENT** -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45$^{th}$ day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

**WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER YOUR COVERAGE UNDER THIS POLICY HAS TERMINATED.**

**GRACE PERIOD** -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid.

**NOTICE OF CLAIMS** -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Policy Number.

**CLAIM FORMS --** When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

**PROOFS OF LOSS** -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

**TIME FOR PAYMENT OF CLAIMS --** All benefits payable under this Policy will be paid upon Our receipt of Proof of Loss.

**PAYMENT OF CLAIMS --** We will pay Policy benefits to You. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

**NO ASSUMPTION OF LIABILITY --** Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

**PHYSICAL EXAMINATIONS** -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

**LEGAL ACTIONS** -- No legal action may be brought to recover on this Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time this Policy requires written proof of loss.

**LIMITATION OF LIABILITY** -- You agree that Our maximum liability under this Policy and related matters is limited to:

1. Policy benefits otherwise payable;
2. Your reasonable attorneys fees, if any; and
3. Any statutory penalties that may be imposed.

**MISSTATEMENTS OF AGE** -- If a Covered Person has misstated his age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Effective Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

**CONFORMITY WITH STATE STATUTES** -- Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the state in which You reside is amended to conform to the minimum requirements of the laws of such state.

**ILLEGAL OCCUPATION** -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

**REFUND OF PREMIUM AT DEATH** – If the Policy is in force when You die, coverage will end and the pro rata unearned portion of any premium paid will be refunded. Unearned premiums will be paid in a lump sum no later than thirty (30) days after We receive proof of Your death.

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**

# HOSPITAL CONFINEMENT INSURANCE POLICY

**THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS. OTHER ADDITIONAL BENEFITS DESCRIBED IN THIS POLICY ARE ALSO PROVIDED.**

# Application to
## American National Life Insurance Company of Texas • P.O. Box 696870 • San Antonio, Texas 78269

Please Print - Use Black Ink ☐ New Policy ☐ Reinstatement Existing #: _____ ☐ Change Existing #:_____

1. Special Requests: Mail Policy to Applicant: ☐ Yes ☐ No Requested Effective Date:_____

2. Please print the full name of all Proposed Insureds (use additional sheet and attach if needed).

| Last, First, Middle Initial | Occupation | Relationship | Sex M/F | Date of Birth | Age | Height | Weight | Social Security Number |
|---|---|---|---|---|---|---|---|---|
| 1. | | Applicant | | | | | | |
| 2. | | Spouse | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |

3. Home Address: _____City:_____State:_____Zip Code:_____

Home Phone: (____)_____Cellular: (____)_____Email Address:_____

I apply for:

4.

Base Plan Daily Benefit Amount: ☐ $ 100 ☐ $ 250 ☐ $ 500 AD&D Beneficiary:_____

Emergency Room Benefit: ☐ $ 250 ☐ $ 500 AD&D Beneficiary Relationship:_____

Increased Daily Benefit Period: ☐ 2 Days ☐ 5 Days ☐ 10 Days

Increased Daily Benefit Amount: ☐ $ 250 ☐ $ 500 ☐ $ 1,000 ☐ $ 1,500 ☐ $ 2,000 ☐ $ 2,500

Base Plan Annual Premium: _____

Optional Benefits:

Critical Illness Rider : ☐ $5,000 ☐ $10,000 _____

Critical Illness Beneficiary: _____ Relationship _____

Outpatient Surgical Rider: ☐ $5,000 ☐ $10,000 _____

Outpatient Diagnostic Imaging Rider: ☐ $2,000 ☐ $3,500 _____

Mode: ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly PAC ☐ List Bill Total Annual Premium: _____

Total Premium Collected with Application: _____

5. Does any Proposed Insured currently have more than one Medical Expense and/or Hospital Indemnity Policy with this or any other company)?..... ☐ Yes ☐ No

If Yes, please name company and give details in chart below:

| Plan Type | Company | To Be Replaced? | Plan Type | Company | To Be Replaced? |
|---|---|---|---|---|---|
| | | ☐ Yes ☐ No | | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No | | | ☐ Yes ☐ No |

## MEDICAL HISTORY AND RELATED INFORMATION

*This plan can not be issued to any person who answers "yes" to question 6, 7, 8, or 9. Do not apply for coverage for this person.*

6. Is any Proposed Insured or family member of the household an expectant mother or expectant father?..... ☐ Yes ☐ No
7. Within the past 2 years, has any Proposed Insured had symptoms, treatment, or been recommended to have treatment for: Alcohol or Drug Abuse, Alzheimer's, Internal Cancer, COPD, Connective Tissue Disorder, Crohn's Disease, Ulcerative Colitis, Cystic Fibrosis, Dementia, Insulin Dependent Diabetes, Emphysema, Heart Attack, Heart Disease, Heart Bypass, Heart Stents, Hepatitis, Cirrhosis of the Liver, Hodgkins Disease, End Stage Renal Disease, Leukemia, Lupus Erythematosus, Multiple Sclerosis, Muscular Dystrophy, Organ Transplant (except corneal), Parkinson's Disease, Paralysis, Peripheral Vascular Disease, Stroke, TIA or Amyotrophic Lateral Sclerosis (ALS)?..... ☐ Yes ☐ No
8. Has any Proposed Insured been diagnosed by a physician, or tested positive or treated for HIV, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other Immune Disorder?..... ☐ Yes ☐ No
9. Has any Proposed Insured been advised to be admitted to a hospital, nursing home, clinic, or other institution for diagnosis or treatment, or had surgery or medical tests recommended, but not yet performed?..... ☐ Yes ☐ No

## MEDICAL HISTORY AND RELATED INFORMATION ***continued***

10. Has any Proposed Insured ever been declined, restricted, rated-up, or postponed for any kind of life or health insurance with this or any other company? ☐ Yes ☐ No
    If Yes, give details: _____
11. Has the Applicant used any form of tobacco within the past 12 months? ☐ Yes ☐ No
    Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months? ☐ Yes ☐ No
12. Has any Proposed Insured within the past 2 years, taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing(any type), motorcycle riding, professional sports, piloting aircraft(any type), or rodeo events? ☐ Yes ☐ No
    If Yes, indicate actvity and give details: _____
13. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's, or been arrested within the past 2 years? ☐ Yes ☐ No
    If Yes, give details and provide Driver's License # and state of issue: _____
14. Has any Proposed Insured received medical counseling, been treated in an emergency room or urgent care center, been admitted to any hospital, nursing home, clinic, or other institution for diagnosis or treatment within the past 2 years? ☐ Yes ☐ No
15. Has any Proposed Insured taken a medication recommended or prescribed by a Physician in the past 12 months? ☐ Yes ☐ No
16. Has any Proposed Insured had symptoms of, or been treated for, any of the following within the past 2 years:

| | | | |
|---|---|---|---|
| ☐ Chest Pain | ☐ Lung/Respiratory | ☐ Intestines or Colon | ☐ Mental or Nervous Disorder |
| ☐ Joints/Knees/Spine | ☐ Reproductive Organs | ☐ Kidneys | |
| ☐ Hernia | ☐ Gallbladder | ☐ Liver | |
| ☐ Prostate Disorder | ☐ Urinary Tract | ☐ Pancreas | |

Give full details below of all "Yes" answers to questions 14-16, include all dates, names and addresses of hospitals and all Physicians, nature of the condition or impairment, the treatment or advice given, and if released from the treatment (use additional sheet and attach if needed).

| Question Number | Proposed Insured | Date of Treatment Begin | - End | Reason for Condition Diagnosis, Injury, etc. | Degree of Recovery | Name/Address of Attending Physicians Street, City, State |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

## APPLICATION DECLARATION AND AGREEMENTS

ATTENTION — After this application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I have received *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare.

FRAUD WARNING — Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, submits an application for insurance or makes a claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information may be guilty of a felony.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned represents that the answers and statements on this application are true, complete, and correctly recorded; and agree they will be used to determine each Proposed Insured's eligibility for coverage under the health insurance plan requested hereby. I understand and agree that: 1. all statements and answers in this application and in any supplements or amendments to it are complete and true; 2. any incorrect or incomplete information on this application may result in loss of coverage or claim denial; 3. no insurance shall take effect unless a policy is issued (or this application is made to change or reinstate an existing policy, unless the change is approved) and actually delivered to the Applicant and the first full premium paid during the lifetime and continued health of all Proposed Insureds as represented in this application. I will notify and provide the Company with any evidence required by it to determine my future eligibility under the policy issued.

If this application is taken over the telephone or electronically, I agree that my electronic signature serves as my original signature.

I understand and agree that:

1. eligibility for the Plan does not constitute initial coverage under the Plan; and
2. initial coverage under the Plan is subject to the Company's criteria.

Signed at _____ _____
City State Zip Code Date

_____ _____
Applicant's Signature Spouse's Signature (if coverage is requested for spouse)

Agent Name: _____ ANTEX Writing Number: _____

Fax Number: _____ Email Address: _____

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the MIG, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured. It is understood that AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:
1. Such information will be used by AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3. A picture copy or photocopy of this authorization shall be as valid as the original; and
4. I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

_____ Signed at City and State

_____ Applicant's Signature

_____ Date

_____ Spouse's Signature (if coverage is requested for spouse)

_____ Witness

_____ Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one)power of attorney, guardian-in-fact, guardian, payee representative or other_____.

## BILLING INFORMATION

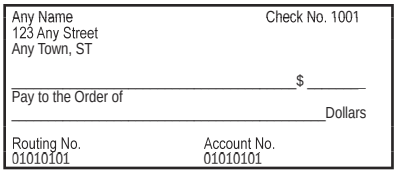
Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Electronic Debit

☐ Cash collected with Application $_____ ☐ Draft Initial Premium $_____

Monthly Electronic Withdrawals

Desired withdrawal date (1-28) _____ ☐ Checking ☐ Savings

*(Funds to be withdrawn from the account number shown on a CWA, otherwise, submit a copy of a voided check or deposit slip to establish a different account for premium withdrawal.)*


Any Name
123 Any Street
Any Town, ST
Check No. 1001
_____ $ _____
Pay to the Order of
_____ Dollars
Routing No. 01010101
Account No. 01010101

Bank Name:_____

City:_____ State:_____

Routing Number:_____ Account Number: _____

Credit Card Information

*Credit Card Payment for Initial Premium Only.* Payment Amount $_____ ☐ VISA ☐ Mastercard ☐ Discover Card

Credit Card Number:_____ Expiration Date:_____

Three Digit Code on Back of Card: _____ Print Name of Cardholder: _____

Billing Address: _____ City: _____ State:____ Zip: _____

Cardholder Signature: _____ If Insurance Premium Payor is not Applicant please provide the following:

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone: (____)_____

## FAIR CREDIT REPORTING ACT (FCRA) PRE-NOTIFICATION

Federal and state law requires notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing proper identification, you may inspect or receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of you family, employers or business associates, financial sources, friends, neighbors or other with whom you are acquainted. The information will consist, when applicable, of a confirmation or your identity, age, residence, marital status and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.

## MEDICAL INFORMATION BUREAU (MIB) PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. American National Life Insurance Company of Texas, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Life Insurance Company of Texas, or its reinsurers, may also release information in its file to other insurance companies to who you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

THIS PAGE IS TO BE LEFT WITH THE APPLICANT AT THE POINT OF SALE

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**
**(referred hereafter as "We", "Our", "Us" or "the Company")**

# HOSPITAL CONFINEMENT INSURANCE POLICY
# OUTLINE OF COVERAGE
# POLICY FORM SERIES ANL-HOPS11

**Coverage provided by the Policy is Hospital Confinement Insurance and it provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.**

1. Read your Policy carefully. This Outline of Coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual Policy provisions control. The Policy itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Hospital Confinement coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalizations resulting from a covered accident or sickness, subject to any limitations set forth in the Policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits described below.

3. **BENEFITS**

| **BENEFIT** | **BENEFIT AMOUNT** |
|---|---|
| Medical Transport Benefit…….... | 50% of initial Hospital Confinement Benefit |
| Emergency Room Benefit…… | [$250 or $500] |
| Initial Hospital Confinement Benefit…… | [$250-$2,500 (in $50 increments)] per Day |
| Benefit Period…… | [2, 5, 10] Days |
| Hospital Confinement Benefit…….. | [$100, $250, $500] per Day |
| Maximum Number of Days…….. | 365 Days |
| Well Newborn Benefit…… | See Policy Provision |
| Intensive Care Unit Benefit…….. | See Policy Provision |
| Outpatient Surgery Benefit…… | $500 per Covered Person per Calendar Year |
| Outpatient Diagnostic Imaging Benefit…… | $250 per Covered Person per Calendar Year |
| Convalescent/Skilled Nursing Facility Confinement…… | $100 per Day |
| Home Health Care Benefit…… | $50 per Day |
| Death Benefit…….. | $10,000 |
| Loss of Sight or Limbs…….. | See Policy Provision |

4. **EXCEPTIONS, LIMITATIONS AND REDUCTIONS**

**A. EXCEPTIONS**

**THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EVENTS.**

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace or remove breast implants; however, this Exception does not apply when surgery is required:

   a. to correct damage for a covered Injury or Sickness;
   b. to repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c. for reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in the Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous or morbid obesity.

13. Treatment provided outside the United States of America, its possessions and territories.

~~14. Routine newborn care.~~

15. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

16. Treatment of alcohol or drug use.

**B. LIMITATIONS**

1. The Company may reduce or deny a claim or void the Policy until such Policy has been in effect for one year, if you make an omission or misrepresentation of material fact in the application for the Policy;

2. The Company may deny or void the Policy at any time if you made a fraudulent material misrepresentation in the application for the Policy.

**PREEXISTING CONDITION** means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 12 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 12 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 12 months of coverage.

5. **RENEWABILITY**

We can terminate coverage under the Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments;

2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of the Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under the Policy's General Provisions; or

3. A Covered Person ceases to be eligible for continued coverage under the Policy as described in the Section of the Policy titled **LOSS OF ELIGIBILITY**.

6. **PREMIUMS**

| | |
|---|---|
| **Initial Premium:** | **$**_____ As stated in Section 5, premiums are subject to change. |
| **Mode of Payment Selected:** | ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC |
| **Initial Modal Premium:** | $_____ |

The Policy has a 31-day Grace Period.

Premiums are subject to change.

**This Outline is a brief description of the Policy terms and provisions. Refer to the Policy for further details.**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ANTX-127366701* | *State:* | *Arkansas* |
| *Filing Company:* | *American National Life Insurance Company of Texas* | *State Tracking Number:* | *49548* |
| *Company Tracking Number:* | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *MIG GAP* | | |
| *Project Name/Number:* | */* | | |

# Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|---|---|---|---|---|
| 08/12/2011 | Form | HOSPITAL CONFINEMENT INSURANCE POLICY | 08/19/2011 | Policy_with_Schedule.pdf (Superceded) |
| 08/12/2011 | Form | APPLICATION | 08/19/2011 | GAP - Generic App.pdf (Superceded) |
| 08/12/2011 | Form | OUTLINE OF COVERAGE | 08/19/2011 | GAP OUTLINE.pdf (Superceded) |

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**

A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**

**HOSPITAL CONFINEMENT INSURANCE POLICY**

This Policy is a contract of insurance. **READ IT CAREFULLY.**

We pay benefits in accordance with all the terms and conditions of this Policy.

**IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION -** You should read Your Application and all documents attached to Your Policy. **Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

Your Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy.

We do not provide coverage until Your Application has been approved and Your Initial Premium is paid. The Initial Premium pays for Your Initial Term of coverage. Your Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Effective Date. Coverage is continued in accordance with all of the provisions of this Policy.

**30 DAY RIGHT TO EXAMINE THIS POLICY** – You may return this Policy to Us for any reason within 30 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Policy, coverage under this Policy is void from the beginning. We will refund any premium paid.

**GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER – SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL.** You have the right to continue this Policy in force subject to the termination provisions and Your continued payment of premium in accordance with all the provisions of this Policy.

**PREMIUMS ARE SUBJECT TO CHANGE -** Please refer to the section titled **PREMIUMS**.

**SECRETARY** **PRESIDENT**

**THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS. OTHER ADDITIONAL BENEFITS DESCRIBED IN THIS POLICY ARE ALSO PROVIDED.**

## POLICY SCHEDULE

| BENEFIT | BENEFIT AMOUNT |
|---|---|
| **MEDICAL TRANSPORTATION BENEFIT** | 50% of Initial Hospital Confinement Benefit |
| **EMERGENCY ROOM BENEFIT** | [$250, $500] |
| **INITIAL HOSPITAL CONFINEMENT BENEFIT** | [$250 - $2,500(in $50 increments)] per Day |
| **BENEFIT PERIOD** | [2, 5,10] Days |
| **HOSPITAL CONFINEMENT BENEFIT** | [$100, $250, $500] per Day |
| **MAXIMUM NUMBER OF DAYS** | [365] Days |
| **INTENSIVE CARE UNIT BENEFIT** | SEE PROVISION |
| **OUTPATIENT SURGERY BENEFIT** | $500 Per Covered Person, Per Calendar Year |
| **OUTPATIENT DIAGNOSTIC IMAGING BENEFIT** | $250 Per Covered Person, Per Calendar Year |
| **CONVALESCENT/SKILLED NURSING FACILITY CONFINEMENT** | $100 per Day |
| **HOME HEALTHCARE BENEFIT** | $50 per Day |
| **DEATH BENEFIT** | $10,000 |

**OPTIONAL COVERAGE:**

| | BENEFIT AMOUNT |
|---|---|
| **CRITICAL ILLNESS BENEFIT RIDER**…….. | [$5,000; $10,000] |

| | MAXIMUM BENEFIT |
|---|---|
| **DIAGNOSTIC IMAGING BENEFIT AND ACCIDENT RIDER**……. | [$2,000 OR $3,500] |

| | BENEFIT OPTION | MAXIMUM CALENDAR YEAR BENEFIT |
|---|---|---|
| **OUTPATIENT SURGERY BENEFIT RIDER**…… | [A or B] | [$5,000; $10,000] |

**POLICY NUMBER** - xxxxxxxxxxxx
**EFFECTIVE DATE** - August 1, 2011

| COVERED PERSONS | RELATIONSHIP | AGE | DATE OF BIRTH |
|---|---|---|---|
| JJ ANICO | POLICYHOLDER | 31 | 04/22/1980 |
| GG ANICO | SPOUSE | 24 | 04/16/1986 |

**TABLE OF CONTENTS**

## PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to Your first Policy anniversary, unless coverage changes. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 60 days notice before any premium change.

## DEFINITIONS

**BODILY INJURY** is the unforeseen, unexpected, unanticipated result of an act or event that causes You to require medical treatment within 48 hours of such act or event.

**CALENDAR YEAR** means the twelve-month period that begins January 1 and ends December 31, each year.

**CLOSE RELATIVE** means anyone related to You by blood, marriage, or adoption; or a court appointed representative.

**COMPLICATIONS OF PREGNANCY** means either of these two general types of conditions:

1. **TYPE I CONDITIONS:** The pregnancy does not end. The cause of the complication is distinct from the pregnancy. Examples include acute nephritis, nephrosis, and cardiac decompensation. There may be other similar conditions as well.

2. **TYPE II CONDITIONS**: The pregnancy ends. Any of the following may occur: delivery by Medically Necessary Cesarean section, ending of ectopic pregnancy, or spontaneous ending of pregnancy that takes place when a live birth is not possible.

**THE FOLLOWING CONDITIONS ARE NOT COMPLICATIONS OF PREGNANCY:** false labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage. We will not consider such a condition as a Complication of Pregnancy.

**CONVALESCENT/FACILITY SKILLED NURSING FACILITY** is a facility accredited by Medicare as a facility capable of providing 24 hour skilled nursing service and the following services: physical, occupational, speech and respiratory therapy. This facility may also be a ward, floor or other area contained within a Hospital and for which the primary purpose is skilled nursing care. Its main purpose must not be to provide custodial care, educational care, or rest care for the aged or treatment such as that provided by a clinic or drug alcohol rehabilitation center.

**COVERED PERSON** means each person named as a Covered Person on the Policy Schedule whose coverage under this Policy has not terminated.

**DIAGNOSTIC IMAGING** means Magnetic Resonance Imaging (**MRI**), Magnetic Resonance Angiography (**MRA**), Computed Axial Tomography (**CAT** Scans), Positron Emission Tomography (**PET** Scans), or Computed Tomography (**CT** scans).

**DOCTOR** means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under this Policy, and acting within the scope of that license.

**EFFECTIVE DATE** means the date, shown in Your Policy Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Effective Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

**EMERGENCY** means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. placing the Covered Persons health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

**EMERGENCY ROOM (ER)** means the department of a Hospital responsible for the provision of medical and surgical care to patients arriving at the Hospital in need of immediate Emergency care.

**HOSPITAL** means an institution that:
1. operates as a Hospital pursuant to law;
2. operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
3. provides 24-hour nursing service by Registered Nurses on duty or on call;
4. has a staff of one or more Physicians available at all times;
5. provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following whether free-standing or a section of another facility: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial or educational care; (c) facilities primarily affording rehabilitative care; or (d) facilities for the aged, drug addicts or alcoholics.

**HOSPITAL CONFINED** means that a Covered Person is admitted to a Hospital as an overnight resident bed patient. This term does not relate to a Covered Person's treatment in a Same Day Surgery facility, Emergency room, an observation room, or confinement in a Rehabilitation Facility.

**HOSPITAL STAY** means the period of time, measured in days from the date of Hospital Admission to the date of discharge, a Covered Person is Hospital Confined. For purposes of calculating benefits, successive Hospital Stays for the same or related causes, separated by 180 days or less, during which no Hospital Confinement occurs, will be treated as a single Hospital Stay.

**INJURY** (Injured) means accidental Bodily Injury sustained by the Covered Person which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under this Policy is in force.

**INTENSIVE CARE UNIT (INCLUDING CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT)** means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

**LIMITING AGE** for Your children is age 26.

**MEDICAL TRANSPORTATION** means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. Transportation by a common carrier is not covered.

**MEDICALLY NECESSARY** means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:
1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**MENTAL DISORDER** means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

**POLICYHOLDER** means You, the Applicant named in the attached Application, any successor thereof, or any person named to assume ownership privileges under this Policy after the original Policyholders death. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

**PREEXISTING CONDITION** means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 12 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 12 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 12 months of coverage.

**REHABILITATION FACILITY** means a specialized section of a Hospital or a properly licensed free standing facility that provides services under the direction of a Doctor that are rehabilitative or restorative; and are consistent with the standards of practice for rehabilitative medicine.

**SURGERY FACILITY** means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term “Same Day Surgery Facility” does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor’s office or Clinic.

**SICKNESS** means a Covered Person’s illness, disease, or condition that begins after the Effective Date and while such Covered Person has coverage under this Policy. Sickness also includes an illness, disease or condition that begins before the Effective Date if it is shown on the Covered Person’s Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while this Policy’s coverage in effect for the Covered Person.

**US, WE, OUR or THE COMPANY** means American National Life Insurance Company of Texas (ANTEX).

**YOU or YOUR** means the Applicant, named in the attached Application.

## BENEFIT

In order for the Company to pay any benefit, described below, the following conditions must be met:
1. The described benefit service must begin after the Covered Person’s Effective Date;
2. The described benefit service must be for the Medically Necessary treatment of a Covered Person’s Injury or Sickness; and
3. The described benefit service must begin and continue while the Covered Person’s coverage remains in effect under this Policy.

**MEDICAL TRANSPORTATION BENEFIT** – If a Covered Person requires Medical Transportation, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each trip, up to 2 trips per Covered Person, per Calendar Year.

**EMERGENCY ROOM (ER) BENEFIT** – If a Covered Person receives treatment in a Hospital Emergency room, We will pay the Emergency Room Benefit, shown on the Policy Schedule. Payment of this benefit is limited to 2 ER treatment visits per Covered Person, per Calendar Year.

**INITIAL HOSPITAL CONFINEMENT BENEFIT -** The Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital Confined. This Benefit is payable from the Covered Person’s first day of Hospital Confinement for the Benefit Period for this benefit, shown in Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

**HOSPITAL CONFINEMENT BENEFIT –** After expiration of the Initial Hospital Confinement Benefit Period, the Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital

Confined, up to the Maximum Number of Days for any one Hospital Stay shown on Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

**INTENSIVE CARE UNIT BENEFIT -** The Company will pay [2] times the amount otherwise payable under the applicable Hospital Confinement Benefit when a Covered Person is confined in an Intensive Care Unit up to a maximum of [30] days for any one Hospital Stay.

**OUTPATIENT SURGERY BENEFIT -** If a Covered Person has surgery performed in a Surgery Facility and is not Hospital Confined at the time of the Surgery, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule.

**OUTPATIENT DIAGNOSTIC IMAGING BENEFIT -** If a Covered Person has Diagnostic Imaging performed and is not Hospital Confined at the time of such procedure, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule.

**CONVALESCENT/SKILLED NURSING FACILITY (CSNF) CONFINEMENT BENEFIT -** If a Covered Person is admitted to a CSNF immediately following a covered Hospital Confinement of at least one day, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they remain in the CSNF, up to a maximum 30 days per Calendar year. However, if benefits are also payable under the **HOME HEALTH CARE BENEFIT**, the 30 days, otherwise available under this benefit are reduced by the total number of days for which Home Health Benefits are paid.

**HOME HEALTH CARE BENEFIT -** If a Covered Person receives Home Health Care immediately following a covered Hospital Confinement or CSNF confinement of at least 3 days, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they receive Home Health Care, up to a maximum 30 days per Calendar year. However, if benefits are also payable under the **CSNF BENEFIT**, the 30 days, otherwise available under this benefit are reduced by the total number of days for which CSNF Benefits are paid.

**DEATH BENEFIT** – We will pay the Death Benefit shown on the Policy Schedule if You die as the result of an Injury You sustain while You are covered under this Policy. In order for the Benefit to be paid, Your death must occur within 100 days of the Injury. This benefit will be paid to the Beneficiary named in Your application, if living. Otherwise, this benefit is payable to Your estate.

**LOSS OF SIGHT OR LIMBS –** If You sustain a loss described in the following table while You are covered under this Policy, We will pay the respective Benefit shown in the table. Loss of a hand or foot means the complete severance of the hand or foot, at or above the wrist or ankle. Loss of sight means the total, permanent, and irreversible loss of sight with no expectation of recovery. The inability to see while You are in a coma is NOT "Loss of Sight" under this Rider and no benefit is payable.

| LOSS | BENEFIT |
|---|---|
| **LOSS OF BOTH HANDS** | **DEATH BENEFIT** |
| **LOSS OF BOTH FEET** | **DEATH BENEFIT** |
| **LOSS OF SIGHT OF BOTH EYES** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND AND ONE FOOT** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND AND SIGHT OF ONE EYE** | **DEATH BENEFIT** |
| **LOSS OF ONE FOOT AND SIGHT OF ONE EYE** | **DEATH BENEFIT** |
| **LOSS OF ONE HAND** | **½ DEATH BENEFIT** |
| **LOSS OF ONE FOOT** | **½ DEATH BENEFIT** |

## EXCEPTIONS

**THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EXCEPTED EVENTS.**

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:

   a) To correct damage for a covered Injury or Sickness;
   b) To repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c) For reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in this Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.

13. Treatment provided outside the United States of America, its possessions and territories.

14. Routine newborn care.

15. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

16. Treatment of alcoholism or drug use.

## AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

A child born to or adopted by You will become a Covered Person under this Policy.

**Newborns:** Coverage for newborn children is free for the fist 90 days from the date of birth.

**Adopted Children:** Coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. The coverage is free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of this Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

## TERMINATION OF COVERAGE

We can terminate coverage under this Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of this Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
3. A Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY**.
4.

## LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Policy Schedule and occurs on such date next following the date of the event that causes such termination.

**RULES FOR ALL COVERED PERSONS** - Coverage will end:

1. If this Policy is terminated in accordance with the section titled TERMINATION OF COVERAGE; or
2. If You fail to pay the required premium within the Grace Period.

**RULES FOR ADULT COVERED PERSONS** - Coverage will end:

1. For Your spouse if there is a divorce; or
2. For a mentally or physically disabled Covered Person if he/she marries or becomes capable of self-support;

If You are married and die and Your spouse is a Covered Person, Your spouse will become the Policyholder.
**RULES FOR CHILD COVERED PERSONS** - Coverage will end for a child when:

1. The child is no longer a dependent of Yours;
2. The child gets married;
3. The child attains the Limiting Age, except for the extension allowed by the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN; or
4. Neither You nor Your spouse remains covered under this Policy.

**PREMIUM** – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

## EXTENSION OF COVERAGE FOR SOME CHILDREN

When a dependent child who is a Covered Person that has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of self-sustaining employment, by reason of mental or physical handicap, and is chiefly dependent upon You for support and maintenance. The child will continue as a Covered Person if, in response to Our inquiry, You submit written proof of the child's incapacity and pay the premium for the child. The premium will be on the same basis as that for an adult of like age and sex. Extension of coverage will not continue for any child named in the Enrollment Application whose disabling condition existed prior to the Effective Date of such child's coverage and was not disclosed in the Enrollment Application.

## CONVERSION PRIVILEGE

If coverage under this Policy has been terminated, Covered Persons may be entitled to have a conversion policy issued by ANTEX that provides coverage similar to this Policy, without evidence of insurability, subject to the following terms and conditions.

A conversion policy is not available to a Covered Person if termination of his insurance under this Policy occurs:

1. Because he/she failed to make timely payment of any required premium; or
2. For any other reason, and he had not been continuously covered under this Policy, and for similar benefits under any policy which it replaced, during the entire three (3) months period ending with such termination; or
3. Because this Policy terminated and the insurance was replaced by similar coverage under another policy within thirty-one (31) days of the date of termination; and
4. Written application and the first premium payment for the conversion policy shall be made to ANTEX not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with ANTEX's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of ANTEX, a separate conversion policy may be issued to cover any dependent.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

## GENERAL PROVISIONS

**ENTIRE CONTRACT --** The Entire Contract will consist of:

1. This Policy;
2. Your Application and attached papers; and
3. Any riders, endorsements or amendments issued with or added to this Policy.

We will deem all the statements provided in any attached Application and attached supplements, except fraudulent statements, as representations and not warranties.

**TIME LIMIT ON CERTAIN DEFENSES --**

**1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION** --
After 1 year from the date a Covered Person becomes insured under this Policy, We may only use fraudulent misstatements in the Enrollment Application to void coverage under this Policy or to deny any claim for loss incurred after such 1 year period.

**2. PRE-EXISTING CONDITIONS** --
No claim for loss incurred after 12 months from the Effective Date will be reduced or denied because a Sickness or Injury, not excluded by name or specific description before the date of loss, existed 12 months before the Effective Date.

**REINSTATEMENT** -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

**WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER YOUR COVERAGE UNDER THIS POLICY HAS TERMINATED.**

**GRACE PERIOD** -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid.

**NOTICE OF CLAIMS** -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Policy Number.

**CLAIM FORMS --** When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

**PROOFS OF LOSS** -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

**TIME FOR PAYMENT OF CLAIMS --** All benefits payable under this Policy will be paid upon Our receipt of Proof of Loss.

**PAYMENT OF CLAIMS --** We will pay Policy benefits to You. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

**NO ASSUMPTION OF LIABILITY --** Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

**PHYSICAL EXAMINATIONS** -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

**LEGAL ACTIONS** -- No legal action may be brought to recover on this Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time this Policy requires written proof of loss.

**LIMITATION OF LIABILITY** -- You agree that Our maximum liability under this Policy and related matters is limited to:

1. Policy benefits otherwise payable;
2. Your reasonable attorneys fees, if any; and
3. Any statutory penalties that may be imposed.

**MISSTATEMENTS OF AGE** -- If a Covered Person has misstated his age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Effective Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

**CONFORMITY WITH STATE STATUTES** -- Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the state in which You reside is amended to conform to the minimum requirements of the laws of such state.

**ILLEGAL OCCUPATION** -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

**REFUND OF PREMIUM AT DEATH** – If the Policy is in force when You die, coverage will end and the pro rata unearned portion of any premium paid will be refunded. Unearned premiums will be paid in a lump sum no later than thirty (30) days after We receive proof of Your death.

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**

# HOSPITAL CONFINEMENT INSURANCE POLICY

**THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS. OTHER ADDITIONAL BENEFITS DESCRIBED IN THIS POLICY ARE ALSO PROVIDED.**

# Application to
# American National Life Insurance Company of Texas • P.O. Box 696870 • San Antonio, Texas 78269

Please Print - Use Black Ink ☐ New Policy ☐ Reinstatement Existing #: _____ ☐ Change Existing #:_____

1. Special Requests: Mail Policy to Applicant: ☐ Yes ☐ No Requested Effective Date:_____

2. Please print the full name of all Proposed Insureds (use additional sheet and attach if needed).

| Last, First, Middle Initial | Occupation | Relationship | Sex M/F | Date of Birth | Age | Height | Weight | Social Security Number |
|---|---|---|---|---|---|---|---|---|
| 1. | | Applicant | | | | | | |
| 2. | | Spouse | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |

3. Home Address: _____City:_____State:_____Zip Code:_____

Home Phone: (_____)_____Cellular: (____)_____Email Address:_____

I apply for:

4.

Base Plan Daily Benefit Amount: ☐ $ 100 ☐ $ 250 ☐ $ 500 AD&D Beneficiary:_____

Emergency Room Benefit: ☐ $ 250 ☐ $ 500 AD&D Beneficiary Relationship:_____

Increased Daily Benefit Period: ☐ 2 Days ☐ 5 Days ☐ 10 Days

Increased Daily Benefit Amount: ☐ $ 250 ☐ $ 500 ☐ $ 1,000 ☐ $ 1,500 ☐ $ 2,000 ☐ $ 2,500

Optional Benefits: Base Plan Annual Premium: _____

Critical Illness Rider : ☐ $5,000 ☐ $10,000 _____

Critical Illness Beneficiary: _____ Relationship _____

Outpatient Surgical Rider: ☐ $5,000 ☐ $10,000 _____

Outpatient Diagnostic Imaging Rider: ☐ $2,000 ☐ $3,500 _____

Mode: ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly PAC ☐ List Bill Total Annual Premium: _____

Total Premium Collected with Application: _____

## MEDICAL HISTORY AND RELATED INFORMATION

*This plan can not be issued to any person who answers "yes" to question 5, 6, 7, or 8. Do not apply for coverage for this person.*

5. Is any Proposed Insured or family member of the household an expectant mother or expectant father? ☐ Yes ☐ No

6. Within the past 2 years, has any Proposed Insured had symptoms, treatment, or been recommended to have treatment for: Alcohol or Drug Abuse, Alzheimer's, Internal Cancer, COPD, Connective Tissue Disorder, Crohn's Disease, Ulcerative Colitis, Cystic Fibrosis, Dementia, Insulin Dependent Diabetes, Emphysema, Heart Attack, Heart Disease, Heart Bypass, Heart Stents, Hepatitis, Cirrhosis of the Liver, Hodgkins Disease, End Stage Renal Disease, Leukemia, Lupus Erythematosus, Multiple Sclerosis, Muscular Dystrophy, Organ Transplant (except corneal), Parkinson's Disease, Paralysis, Peripheral Vascular Disease, Stroke, TIA or Amyotrophic Lateral Sclerosis (ALS)? ☐ Yes ☐ No

7. Has any Proposed Insured been diagnosed by a physician, or tested positive or treated for HIV, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other Immune Disorder? ☐ Yes ☐ No

8. Has any Proposed Insured been advised to be admitted to a hospital, nursing home, clinic, or other institution for diagnosis or treatment, or had surgery or medical tests recommended, but not yet performed? ☐ Yes ☐ No

## MEDICAL HISTORY AND RELATED INFORMATION ***continued***

9. Has any Proposed Insured ever been declined, restricted, rated-up, or postponed for any kind of life or health insurance with this or any other company? ☐ Yes ☐ No
   If Yes, give details: _____
10. Has the Applicant used any form of tobacco within the past 12 months? ☐ Yes ☐ No
    Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months? ☐ Yes ☐ No
11. Has any Proposed Insured within the past 2 years, taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing(any type), motorcycle riding, professional sports, piloting aircraft(any type), or rodeo events? ☐ Yes ☐ No
    If Yes, indicate actvity and give details: _____
12. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's, or been arrested within the past 2 years? ☐ Yes ☐ No
    If Yes, give details and provide Driver's License # and state of issue: _____
13. Has any Proposed Insured received medical counseling, been treated in an emergency room or urgent care center, been admitted to any hospital, nursing home, clinic, or other institution for diagnosis or treatment within the past 2 years? ☐ Yes ☐ No
14. Has any Proposed Insured taken a medication recommended or prescribed by a Physician in the past 12 months? ☐ Yes ☐ No
15. Has any Proposed Insured had symptoms of, or been treated for, any of the following within the past 2 years:

| | | | |
|---|---|---|---|
| ☐ Chest Pain | ☐ Lung/Respiratory | ☐ Intestines or Colon | ☐ Mental or Nervous Disorder |
| ☐ Joints/Knees/Spine | ☐ Reproductive Organs | ☐ Kidneys | |
| ☐ Hernia | ☐ Gallbladder | ☐ Liver | |
| ☐ Prostate Disorder | ☐ Urinary Tract | ☐ Pancreas | |

Give full details below of all "Yes" answers to questions 13-15, include all dates, names and addresses of hospitals and all Physicians, nature of the condition or impairment, the treatment or advice given, and if released from the treatment (use additional sheet and attach if needed).

| Question Number | Proposed Insured | Date of Treatment Begin | - End | Reason for Condition Diagnosis, Injury, etc. | Degree of Recovery | Name/Address of Attending Physicians Street, City, State |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

## APPLICATION DECLARATION AND AGREEMENTS

ATTENTION — After this application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I have received *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare.

FRAUD WARNING — Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, submits an application for insurance or makes a claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information may be guilty of a felony.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned represents that the answers and statements on this application are true, complete, and correctly recorded; and agree they will be used to determine each Proposed Insured's eligibility for coverage under the health insurance plan requested hereby. I understand and agree that: 1. all statements and answers in this application and in any supplements or amendments to it are complete and true; 2. any incorrect or incomplete information on this application may result in loss of coverage or claim denial; 3. no insurance shall take effect unless a policy is issued (or this application is made to change or reinstate an existing policy, unless the change is approved) and actually delivered to the Applicant and the first full premium paid during the lifetime and continued health of all Proposed Insureds as represented in this application. I will notify and provide the Company with any evidence required by it to determine my future eligibility under the policy issued.

If this application is taken over the telephone or electronically, I agree that my electronic signature serves as my original signature.

I understand and agree that:

1. eligibility for the Plan does not constitute initial coverage under the Plan; and
2. initial coverage under the Plan is subject to the Company's criteria.

Signed at _____ _____
City State Zip Code Date

_____ _____
Applicant's Signature Spouse's Signature (if coverage is requested for spouse)

Agent Name: _____ ANTEX Writing Number: _____

Fax Number: _____ Email Address: _____

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the MIG, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured. It is understood that AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:
1. Such information will be used by AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3. A picture copy or photocopy of this authorization shall be as valid as the original; and
4. I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

_____ Signed at City and State

_____ Applicant's Signature

_____ Date

_____ Spouse's Signature (if coverage is requested for spouse)

_____ Witness

_____ Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one)power of attorney, guardian-in-fact, guardian, payee representative or other_____.

## BILLING INFORMATION

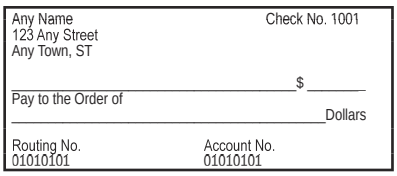
Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Electronic Debit

☐ Cash collected with Application $_____ ☐ Draft Initial Premium $_____

Monthly Electronic Withdrawals

Desired withdrawal date (1-28) _____ ☐ Checking ☐ Savings

*(Funds to be withdrawn from the account number shown on a CWA, otherwise, submit a copy of a voided check or deposit slip to establish a different account for premium withdrawal.)*


Any Name
123 Any Street
Any Town, ST
Check No. 1001
$ _____
Pay to the Order of
Dollars
Routing No. 01010101
Account No. 01010101

Bank Name:_____

City:_____ State:_____

Routing Number:_____ Account Number: _____

Credit Card Information

*Credit Card Payment for Initial Premium Only.* Payment Amount $_____ ☐ VISA ☐ Mastercard ☐ Discover Card

Credit Card Number:_____ Expiration Date:_____

Three Digit Code on Back of Card: _____ Print Name of Cardholder: _____

Billing Address: _____ City: _____ State:____ Zip: _____

Cardholder Signature: _____ If Insurance Premium Payor is not Applicant please provide the following:

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone: (____)_____

## FAIR CREDIT REPORTING ACT (FCRA) PRE-NOTIFICATION

Federal and state law requires notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing proper identification, you may inspect or receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of you family, employers or business associates, financial sources, friends, neighbors or other with whom you are acquainted. The information will consist, when applicable, of a confirmation or your identity, age, residence, marital status and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.

## MEDICAL INFORMATION BUREAU (MIB) PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. American National Life Insurance Company of Texas, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Life Insurance Company of Texas, or its reinsurers, may also release information in its file to other insurance companies to who you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

THIS PAGE IS TO BE LEFT WITH THE APPLICANT AT THE POINT OF SALE

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS**
A Stock Life Insurance Company
**HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550**
**MAILING ADDRESS: P.O. BOX 696990, SAN ANTONIO, TEXAS 78269**
**(referred hereafter as "We", "Our", "Us" or "the Company")**

# HOSPITAL CONFINEMENT INSURANCE POLICY
# OUTLINE OF COVERAGE
# POLICY FORM SERIES ANL-HOPS11

**Coverage provided by the Policy is Hospital Confinement Insurance and it provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.**

1. Read your Policy carefully. This Outline of Coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual Policy provisions control. The Policy itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Hospital Confinement coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalizations resulting from a covered accident or sickness, subject to any limitations set forth in the Policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits described below.

3. **BENEFITS**

| **BENEFIT** | **BENEFIT AMOUNT** |
|---|---|
| Medical Transport Benefit…….... | 50% of initial Hospital Confinement Benefit |
| Emergency Room Benefit…… | [$250 or $500] |
| Initial Hospital Confinement Benefit…… | [$250-$2,500 (in $50 increments)] per Day |
| Benefit Period…… | [2, 5, 10] Days |
| Hospital Confinement Benefit…….. | [$100, $250, $500] per Day |
| Maximum Number of Days…….. | 365 Days |
| Intensive Care Unit Benefit…….. | See Policy Provision |
| Outpatient Surgery Benefit…… | $500 per Covered Person per Calendar Year |
| Outpatient Diagnostic Imaging Benefit…… | $250 per Covered Person per Calendar Year |
| Convalescent/Skilled Nursing Facility Confinement…… | $100 per Day |
| Home Health Care Benefit…… | $50 per Day |
| Death Benefit…….. | $10,000 |
| Loss of Sight or Limbs…….. | See Policy Provision |

4. **EXCEPTIONS, LIMITATIONS AND REDUCTIONS**

**A. EXCEPTIONS**

**THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EVENTS.**

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace or remove breast implants; however, this Exception does not apply when surgery is required:

   a. to correct damage for a covered Injury or Sickness;
   b. to repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c. for reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in the Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous or morbid obesity.

13. Treatment provided outside the United States of America, its possessions and territories.

14. Routine newborn care.

15. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

16. Treatment of alcohol or drug use.

**B. LIMITATIONS**

1. The Company may reduce or deny a claim or void the Policy until such Policy has been in effect for one year, if you make an omission or misrepresentation of material fact in the application for the Policy;

2. The Company may deny or void the Policy at any time if you made a fraudulent material misrepresentation in the application for the Policy.

**PREEXISTING CONDITION** means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 12 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 12 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 12 months of coverage.

5. **RENEWABILITY**

We can terminate coverage under the Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments;

2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of the Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under the Policy's General Provisions; or

3. A Covered Person ceases to be eligible for continued coverage under the Policy as described in the Section of the Policy titled **LOSS OF ELIGIBILITY**.

6. **PREMIUMS**

| | |
|---|---|
| **Initial Premium:** | **$**_____ As stated in Section 5, premiums are subject to change. |
| **Mode of Payment Selected:** | ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC |
| **Initial Modal Premium:** | $_____ |

The Policy has a 31-day Grace Period.

Premiums are subject to change.

**This Outline is a brief description of the Policy terms and provisions. Refer to the Policy for further details.**